Therapeutic Relationships with People Experiencing Psychosis Within an Acute Mental Health Care Setting: A Critical Discursive Evaluation.

By

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Declaration:

I hereby declare that the work submitted in this thesis is fully the result of my own investigation, except where otherwise stated

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Abstract

Literature review: The therapeutic relationship is considered a pivotal underpinning of counselling psychology and is a key determinant of positive therapeutic outcomes in various forms of therapy. Health care professionals (HCPs) utilise the therapeutic relationship within acute mental health settings (AMHS); however, little is known about how this is achieved, particularly with people experiencing symptoms of psychosis who have often experienced interpersonal trauma in their history.

Rationale: There are various discourse resources relating to the therapeutic relationship, AMHS, and psychosis that HCPs draw on to construct their sense-making of; the patient, their professional role, the institution of AMHS and the diagnosis of psychosis. However, there has been no research to date that has explored how HCPs use discursive processes to make sense of the therapeutic relationships they form within this setting and with people experiencing psychosis.

Method: Six semi-structured interviews were conducted with nurses and counselling psychologists, who had experiences of working in AMHS and with people experiencing psychosis. These were transcribed and analysed using Critical Discursive Psychology (CDP; Potter and Wetherell, 1986).

Findings: Four interpretive repertoires were identified within the data: the therapeutic relationship bridges the mental health system and the person experiencing psychosis; the therapeutic relationship as a means to manage psychotic experiences with a boundaried, yet flexible approach; meeting the person experiencing psychosis through the therapeutic relationship; and the therapeutic relationship is more than just a dyad – the MDT. Limitations of this research were addressed, implications for future research and clinical practice were highlighted, and reflexivity was employed and conveyed throughout this work.

Chapter One: Introduction

1.1. Definitions

AMHS	Acute Mental Health Settings
CBT	Cognitive Behavioural Therapy
CCC	Comprehend Cope and Connect
HCP	Health Care Professional
MDT	Multi-Disciplinary Team
MH	Mental Health

1.2. Reflexivity part one: The researcher's relationship to the topic

Donati (2016) states that it is important to develop reflexivity during counselling psychology training to foster self-awareness and personal growth. With regards to research, reflexivity can aid insight into the researcher's own biases and assumptions, bringing them to the surface for evaluation (Willig, 2013). This not only contextualises the findings within this researcher's relationship to the topic and their epistemological stance (Willig, 2013) but also helps promote a research climate of openness and accountability (Wosket, 2002). For these reasons, I offer my reflexivity to illustrate how my involvement could have influenced this research.

My arrival to this research topic has come from my own personal values that originated from my family and upbringing, as well as many life experiences that centre on the theme of the therapeutic relationship. On reflection of my personal values, I can attribute a sense of altruism and the care of others to the familial influences laid out by my mother and paternal grandmother who were both nurses and were my main caregivers. These values gave me an early focus upon meeting the needs of others, doing no harm, and personifying the qualities of humanistic values such as, genuineness, unconditional positive regard and empathy. This gave me a sense of integrity and self-worth and grounded belonging to a set of values that were greater than myself, which could be described as spiritual values. Being of service to others was also a family value that was also reflected in my

grandfather's and father's career in the fire service. Helping others, even outside of the demands of their vocation, was a behaviour that was normalised within their way of being, and in embodying these values this was normalised for me growing up. In my younger years, I can see how these values created a sense of idealism towards these qualities and judgements of anything other than them. As I aged, this idealism shifted, which I noticed as a shift towards more tolerance and compassion for other perspectives. I specifically noticed this shift after having children and entering my 30s. I consider this as a natural, maturing process as my life experiences became assimilated with my familial values. It is highly plausible that growing up in a family that incorporated these values, they would have been highly influential in my personal interests, career choices and in choosing the topic of this thesis.

My first job after leaving college involved turning a childhood passion into a career, as a horse-riding instructor. I valued the experience of working with horses and have learned a lot about building relationships based on trust, mutual respect, and authenticity which was paramount in enabling harmonious work with horses. Teaching people how to ride, also taught me a lot about human nature too. Horses can provoke many dysfunctional ways of coping in the rider, which led to an awareness of the rider's feelings, how these were influencing the horse and a more relational approach to teaching riding and horsemanship. This experiential awareness, alongside studying a BSc in psychology, helped shape my teaching style into a more therapeutic and validating experience for the horse, rider, and myself. This awareness also featured in other roles in my life, such as being a Health Care Support Worker in elderly care and being a mother of two children. Concurrently with my work as a riding instructor and after leaving college, I also worked in a residential nursing home where my mother was the Matron. At this young age working under my mother's authority was quite challenging, however her values were undeniable to me. Being "the patient's advocate" and standing up for the underdog were themes that have also fed into my professional life. This was another value that has had a big influence in my interest in human nature, psychology, Counselling Psychology and topic choice for this thesis.

My interest in psychology grew and I pursued a career in the field by entering into a Counselling Psychology training programme. I considered the topic of the therapeutic relationship for my thesis during a placement in AMHS, which appeared to be a challenging environment to

develop therapeutic relationships with patients, particularly those experiencing psychotic symptoms who can exhibit paranoid and/or threatening behaviour. However, I learned that there was an emphasis for all staff to work as part of the multi-disciplinary team (MDT) whilst providing a recovery-focused approach to patient care. I had the opportunity to attend patient care plan and MDT meetings and found that they promoted an egalitarian team, valued the experiences and opinions of all professionals, and worked holistically towards patients' recovery; although there was also often an air of aloofness within the biomedical talk with a psychiatrist leading the meetings. I learned that the roles of the psychologist within the MDT is multifaceted, but I was most interested in their responsibility to provide support and counsel for frontline staff. However, despite this support, staff are prone to burnout and the wards experience high staff turnover. From talking to the HCPs on the wards and reading research papers exploring their experiences, I was curious as to how they develop therapeutic relationships on busy wards where patients experience acute mental and emotional distress, and often only stay for a short space of time.

This provoked a strong desire to explore these challenges. On reflection, I realised that this may have been due to my own experiences of burnout during my time as an HCP working in the health care industry. I remember feeling caught between trying my best to provide care to patients whilst experiencing unrealistic shift patterns and numbers of patients on my caseload, which left me feeling rushed and stressed, an experience known and discussed amongst staff regularly. I remember wondering why this was bemoaned whilst simultaneously accepted, and my conclusion was that social norms about the roles of patient and HCPs are embedded in our health care culture and normalised within a sense of hopelessness and disempowerment through discourses shared within this setting. This personal experience could position me as a wounded healer (Jung, 1969), which may provoke an over-identification towards participants in this research study and may potentially distort my perception of their experiences. However, being aware of this and employing reflexivity in personal therapy and research supervision will, hopefully, keep these biases in full view and aid the process of exploring this topic.

I was attracted to counselling psychology because of the emphasis on the therapeutic relationship that has followed me throughout my health care and equine professions. I believe that fundamentally there is great importance for humanistic values when connecting with others and this

has driven me to return to health care, this time in the capacity of a counselling psychologist. Due to my history, I acknowledge my sensitivity to the needs of those who care for others. With this in mind, I was inspired by Winnicott's "nursing triad" (cited in Casement, 1985/1997, p.12) and how this could be applied to illustrate the requirements for support in ward staffs' caring role. Casement (1985/1997) described a triangle concerning the supervisor-therapist-client triad, the supervisor holds the therapist, whilst the therapist holds the client. This model appeared to be relevant when considering the psychologist's role within the MDT in an AMHS, in that they are holding the ward staff whilst they hold the patient, enabling them to provide quality patient-centred care whilst working towards their recovery and to provide them with time to reflect on their practice. With this opportunity to explore how HCPs construct their experiences and sense-making of their therapeutic work, I hope to develop a deeper understanding of the qualities of therapeutic relationships in AMHS, the challenges in building therapeutic bonds, and how HCPs might be supported by psychologists within the MDT. This will extend an understanding of how therapeutic relationships are created, developed and sustained, where barriers may include the clinical and discursive environment as well as the patient's level of distress. Such exploration may provide valuable knowledge of clinical practice within counselling psychology and AMHS.

Chapter Two: Critical literature review

2.1. Overview

From a counselling psychology perspective, the therapeutic relationship is considered a vehicle for the therapist to attune to and interpret the phenomenological understanding of another person's meaning-making process (Milton, 2016). This critical review offers an evaluation of the literature regarding the concept of the therapeutic relationship as it pertains to staff working in AMHS. These settings are notoriously challenging due to their function as a place to hold and assist the recovery of people experiencing acute mental health crises, such as suicidal feelings, episodes of acute psychosis, hypomania, or mania (Mind, 2015), in a short timeframe. Patients can be confused, disorientated, and emotionally dysregulated, and HCPs have to negotiate care with difficult emotions present, sometimes at risk of verbal and physical confrontation. It is understood that the therapeutic relationship enables hospital staff to negotiate patient care, however, research suggests that building

a therapeutic relationship can be challenging for various systemic, interpersonal and intrapsychic reasons. Ward staff are pivotal in facilitating good relationships with patients, as their initial interactions during routine ward duties can build trust and open up possibilities for psychological work being sought. Therefore, they could be considered gate-keepers of psychological engagement, making this research relevant to psychologists working in AMHS. Counselling psychology has a vested interest in researching and promoting the therapeutic relationship as it places person-centred care at its heart (Milton, 2016). However, counselling psychology has been underrepresented in research regarding tertiary mental health care settings, and certain diagnoses such as psychosis and schizophrenia (Larsson et al., 2012). Therefore, there is a strong rationale for this topic to be explored from this perspective.

This review explores this topic in five sections. Firstly, the concept of the therapeutic relationship is presented, to frame the research in current mental health (MH) theory and practice. The historical contextual influences of AMHS are also explored, specifically how the past has shaped the culture of these settings. Additionally, research addressing service users' expectations and experiences highlight potential systemic and interpersonal barriers to the therapeutic relationship. Interpersonal barriers are elaborated upon by drawing on HCP perspectives of the therapeutic relationship in AMHS. Lastly, an evaluation of how the concept of diagnosis is understood and worked within AMHS will be presented. This will include how symptoms of psychosis, such as paranoia and voice-hearing, could be considered an intrapsychic barrier that potentially impacts on the therapeutic relationship. This review concludes with a summary of the implications and relevance for counselling psychology, as well as a synopsis and identification of the gaps in the literature, which will inform the research question of this research thesis.

2.2. Method

All literature was found using the psycINFO database by utilising Open Athens, Google Scholar and The Open University search engines. Search terms; "psychiatric nurse", "psychiatric hospital staff", "therapeutic relationship", "psychiatric hospitals", "schizophrenia", and "psychosis" yielded the research evaluated and critiqued in this review.

2.3 The theoretical framework of the therapeutic relationship

2.3.1. Overview

Milton (2016) states that humans are ontologically predisposed to attach, empathise and care, qualities that facilitate relationships, built on an ability to listen to verbal and non-verbal information. The value of the therapeutic relationship lies in the therapist's ability to manage their own emotions and those of the client, normalising emotions and modelling more functional ways of coping (Milton, 2016). Certainly, across different approaches, the therapeutic relationship has been quantitatively associated with positive outcomes (Stiles, 2012; Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Horvath et al., 2011; Friedlander et al., 2011), but little is known about the qualitative constituents of this phenomenon. Considering counselling psychology is a profession that embodies a pluralistic and integrative practice, exploring this topic from this perspective could contribute to further knowledge in this field.

2.3.2. Humanistic perspectives of the therapeutic relationship

Counselling psychology is underpinned by Rogers (1967/1986) person-centred approach, which positions the therapeutic relationship as essential. He proposes that the therapeutic relationship is sufficient and all that is necessary for therapy and outlines this relationship as possessing; unconditional positive regard, empathy, genuineness, and authenticity (Rogers, 1967/1986). He expresses his disdain for the movement towards professionalization, which arguably perpetuates a distance between MH professionals and clients and positions the person as merely a diagnosis or an object. Mearns and Cooper (2017) elaborate on Roger's classical text detailing qualities of the therapeutic relationship in terms of deep engagement known as "relational depth" (p.42), which is not only experienced in humanistic therapies but is certainly built on Rogerian philosophy. This text does not differentiate between various modalities of therapy, but instead attempts to find the common thread that is helpful to develop a sense of "OK-ness" (Mearns & Cooper, 2017, p. xi) in relationship with both the Self and others.

2.3.3. Psychodynamic perspectives of the therapeutic relationship

Psychoanalytic theory, originally developed by Freud (1912), was arguably the first to utilise the therapeutic relationship as a tool to understand the client through transference and countertransference. Strong emotions from the patient changed their attachment to him and he called this transference (Lemma, 2003). These were considered to be attitudes and ideas that the patient held towards the therapist that were associated with previous relational patterns, particularly with their parents (Storr, 1989/2001). Countertransference encapsulates the emotional reactions of the therapist towards the client (Lemma, 2003). Freud (1912) stipulates that transference and countertransference are part of all relational interactions, but in therapy, this emotive connection is interpreted by the therapist and shared with the client, to enlighten the client to their unconscious mind. Klein (1996) adds more detail to the process of transference by describing it as an unconscious splitting and projection of a part of the person onto the therapist that the therapist may identify with, this is known as projective identification (Melanie Klein Trust, 2020).

Bowlby's (1988) attachment theory has informed a deeper understanding of interpersonal relationships and relevant to the topic of the therapeutic relationship, which can form a secure base for therapy. Accordingly, the quality of the connection between a child and their early caregivers describes how individuals may connect with others throughout their lives and influences the styles they employ to cope with their relationships. Secure attachments arise from having one's physical and emotional needs met, encouraging autonomy within a predictable and consistent relationship with the caregiver, and tend to result in individuals having a sense of stability and understanding in relationships. Insecure attachments are subdivided into anxious, avoidant and disorganised styles. Infants who experienced caregivers as not meeting their physical and/or emotional needs may form anxious attachments, leading to a preoccupation with receiving reassurance and a dependency on the other's attention and affections, or avoidant attachments identified by a sense of hopelessness and detachment to others. Disorganised or fearful attachments are identified by a mixture of both anxious and avoidant styles of coping in relationships. Insecure attachments have been associated with some forms of emotional, physical and/or sexual abuse from caregivers, or in infants of parents who have experienced mental or physical health issues (Brisch, 2012). Attachment theory is of significant relevance to how HCP make sense of and form therapeutic relationships with people experiencing

psychosis, as evidence suggests that there is a high prevalence of insecure attachment styles amongst this cohort (Berry et al., 2019; Berry et al., 2008).

2.3.4. Cognitive behavioural perspectives of the therapeutic relationship

Beck (1967/1991) advocates the importance of a therapeutic collaboration between therapist and patient within cognitive behavioural therapy (CBT) and agrees with the humanistic qualities of "genuine warmth, acceptance, and accurate empathy" (p.221) can be readily adopted by therapists when they work alongside the patient, as opposed to assuming an authoritative or superior position in the relationship. Gilbert and Leahy (2007) highlight how psychoanalytic and person-centred theories are incorporated into the CBT model, and Leahy (2001) devotes a chapter to countertransference. Gilbert and Leahy (2007) explain transference as internal constructions of one's sense of self within intersubjective processes with significant others. These mental representations of one's self and others can be automatically provoked by cues in the therapeutic relationship from "cognitive inferences, biases and retrieval; core affective responses and expectations (of being accepted/rejected); motivations (to approach or avoid), and the feelings, thoughts and behaviours evoked in the recipient of the transference" (Gilbert and Leahy, 2007, p.83). Gilbert and Leahy (2007) take the position that a Rogerian approach to the therapeutic relationship is simply concerned with "basic micro-skills and counselling skills" (p.5) that should be covered in training. This perspective hints to possible dialectical rhetoric with the therapeutic relationship being simultaneously considered fundamental and paramount, as well as basic and potentially taken-for-granted.

Specifically, Chadwick (2006) addresses the importance of the therapeutic relationship between therapist and the person experiencing psychosis concluding that the therapeutic relationship becomes increasingly important when working with people experiencing psychosis and schizophrenia due to the complexity and severity of their presentation. In his approach entitled person-based cognitive therapy for psychosis, Chadwick (2006) discusses the notion of "radical collaboration" (p.7), which he states is synonymous to Rogerian concepts of acceptance and viewing the person with unconditional self-worth and stresses this as a fundamental and essential basis for working with people experiencing psychosis.

2.3.5. Third-wave CBT perspectives of the therapeutic relationship

This issue has also received development within process-orientated third-wave CBT. Acceptance and commitment therapy (ACT) (Hayes et al., 2012) and dialectical behavioural therapies (DBT) (Linehan, 1993) appear to have incorporated humanistic, existential, and mindfulness-based elements to grasp both how to be with the client in the therapeutic relationship, as well as impart these concepts onto the client for use in their lives. Comprehend, cope and connect (CCC) integrates several third-wave approaches, as well as psychodynamic principles, into an emotion-focused way of working with people experiencing MH concerns (Clarke & Nicholls, 2018). This approach draws on the Interactive Cognitive Subsystems (ICS) model (Teasdale & Barnard, 1993), which details implicational and propositional ways of knowing. The ICS model conceptualises that the two cognitive subsystems become separated when emotional distress is experienced and the implicational awareness takes over, which manifests in the case of psychosis as a lack of individuality and a more abstract awareness of a reality that may not be shared with others. This model of the mind has also been adopted by Linehan (1993) within DBT, who labels the two subsystems as emotion mind and reasonable mind. The integration of these two minds results in adding "intuitive knowing to emotional experiencing and logical analysis" (Linehan, 1993, p.214). The ICS model also makes sense of human connection, the therapeutic relationship being an aspect of this, and it is proposed that implicational way of knowing is the part of the mind where the patient and therapist share a felt sense on the relational level, where genuine warmth, unconditional positive regard and accurate empathy is felt within the therapeutic relationship. Indeed, Freemantle and Clarke (2009) use a case study approach to highlight the importance of validation of experience, through active listening and expressions of accurate empathy and paraphrasing to build rapport with people experiencing psychosis, who could be subjected to invalidation by being told that their experiences are not real.

2.3.6. Nursing perspectives of the therapeutic relationship

The therapeutic relationship in MH nursing practice has been heavily influenced by Hildegard Peplau. Peplau (1991) discusses nursing in terms of interpersonal relations (IPR) and draws on psychodynamic theory to inform her work. She stresses the importance of nursing to be defined by

the function of the role it provides, and how interpersonal conditions are presented within this role to facilitate health. The IPR theory of nursing details four phases of the nurse-patient relationship; orientation, identification, exploration and resolution, which possess differing requirements of the relationship and can symbolise varied relational roles as the patient moves from illness to recovery; from stranger-stranger to mother-child, to adolescent-counsellor/teacher, and finally adult-adult, respectively (Peplau, 1991). Therefore, effective nursing involves flexibility, and skilful sensitivity, to enable an adaptation to the patient's changing needs and collaboratively work towards recovery, without the patient feeling a sense of stagnation in their illness or pushed too fast towards recovery. How seamlessly this could be implemented may depend on many factors, and how nurses apply this to practice is considered very much experiential and intuitive (Scanlon, 2006).

2.4. History of psychiatric hospitals and mental health

Psychiatric hospitals possess a controversial history whose origins have been reported to start with the Bethlem Royal Hospital in London, founded in 1247, though it did not begin admitting MH patients until 1403 (Historic England, 2018), and institutions grew and became more prevalent up until the mid-twentieth century. Initially, knowledge of MH was embedded in a historically significant comprehension of religious doctrine (Historic England, 2018), supernatural fears, and individual deviance from societal values (Milton et al., 2010). However, over time, scientific knowledge dominated the care and treatment of people experiencing MH concerns (Milton et al., 2010). Opposing ideas were also present during these early days. In 1792, a Quaker named William Tuke developed the York Retreat, a therapeutic setting for people with MH concerns to help rehabilitation without the use of physical restraints (Quakersintheworld, 2018). This contradictory idea was important in offering a different perspective on MH and focused on humanistic treatments being presented through a therapeutic environment which included work and leisure activities. Foucault (2001) discusses the movement he called *The Great Confinement* (p.38), positioning asylums as institutions that aided social control by removing criminals and the homeless from society. Once institutionalised, patients had to rely on survival instincts within them and learned little to help them on returning to society (Smith, 2014). This historical context incited a theoretical movement towards deinstitutionalisation, which was reflected in mid-nineteenth-century literature. From the existential-phenomenological epistemology of *The Divided Self* (Laing, 1960/2010), to the

novel *One Flew Over the Cuckoo's Nest* (Kesey, 1962), literature reflected the humanistic, and anti-psychiatric movement of that time, which offered a person-centred opposition to the existing biomedical, psychiatric treatment regime.

This historical view of MH highlights two opposing views in understanding and treating MH concerns, the biomedical perspective, which includes medicating and restraint methods on one side, and the humanistic therapeutic relationship, which addresses psychosocial elements of individuals' experiences. The biopsychosocial model (Engel, 1977) attempts to balance these perspectives; however, it could be argued that the three elements, biological, psychological and social, are prioritised depending on the focus of the professional and/or patient. Today, patient care is shared across the MDT amongst varied professional roles, psychiatrists, nurses, psychologists, occupational therapists, and health care support workers (Fairfax, 2016). The ethos behind the MDT denotes an awareness of the different professionals involved in patient care have varied perspectives on the patient, and sharing these different perspectives gives a more comprehensive and holistic view of the patient's presentation and possible roads to recovery (Fairfax, 2016; Cowdrill & Dannahy, 2009).

The biomedical and humanistic paradigms within MH care (and health care more broadly) is reflected within policies and guidelines from the Royal College of Psychiatrists' College Centre of Quality Improvement (CCQI) and British Standards Institution (BSI) outlines standards for inpatient MH services which shows some balance between biomedical treatment and humanistic care. This includes; compassionate, respectful and dignified care of patients, primary importance placed on the value of relationships, patient involvement in their care, and access to care and treatment which is safe for patients, carers, and staff (CCQI, 2017). By including the standard "valuing relationships: The value of relationships between people is of primary importance" (CCQI, 2017, p.3), this document frames humanistic values within their standards. However, Cahill et al. (2013) argue that MH nursing is divided into two camps; the therapeutic relationship, and the biomedical, and despite the rhetoric stating the importance of the former, there is much debate as to which camp possesses primacy in everyday practice. However, and in agreement with counselling psychology values (Fairfax, 2016), I intend to not identify too strongly with one camp over the other but to critically engage in both sides of the debate, although concerning the reflexivity it is noted that a questioning and open relationship with my own biases will be required. Additionally, and with consideration to

the ICS model (Teasdale & Barnard, 1993; Clarke & Nicholls, 2018), both the propositional way of knowing (associated with scientific and biomedical knowledge), and implicational ways of knowing/being (associated with humanistic qualities in relating to others) will be equally valued, neither holding superiority over the other as both are equally necessary. Research has addressed this contention and can therefore offer insights into the experience of front-line MH care.

2.5. The therapeutic relationship in AMHS

2.5.1. The therapeutic relationship is marginalised

The National Health Service (NHS) and is a finite resource that provisions for AMHS in the UK. As such, there is a high expectation for short admissions and maintaining safety. Accordingly, medical interventions are often favoured over psychological approaches due to offering more immediate responses to a crisis. Fairfax (2016) suggests that politico-economic factors, a desire to hit outcome targets and issues of accountability drive this dynamic. Therefore, the therapeutic relationship, personal experiences and social constructs may not be regarded with the same consideration as medical interventions that are captured more readily by quantitative methods. These systemic factors highlight possible barriers to developing therapeutic relationships in AMHS because they are more challenging to quantify. Nonetheless, as Browne et al (2012) suggest, it is in need of being evaluated and operationalised.

However, qualitative research has indicated support for a focus on the therapeutic relationship. Morvillers and Rothan-Tondeur (2017) found the theme; Proximal Zone of Therapeutic Alliance (PZTA), using Nvivo computerised qualitative analysis, which captured patients' desire for proximity and attachment to ward staff, and recommended staff training for therapeutic relationship development. Additionally, Shattell et al. (2007) found three themes from patients' experiences of the therapeutic relationship; related to me, know me as a person, and get to the solution, and concluded that authentic nurses engendered authentic patients, a Rogerian quality of the therapeutic relationship (Rogers, 1967/1986). These qualitative studies utilised computerised software that afforded them generous samples and presents clear and concise themes that appear to meet the aims of the study. They were also grounded in existing theory, add a patient voice to the body of literature

within this topic from a nursing perspective, and can offer valid results that can hold weight in building new knowledge within this topic.

Thibeault et al. (2010) used a phenomenological methodology, with a sample of six participants and found that patients experienced staff-patient relationships as meaningful and can be either affirming or hurtful. They concluded that therapeutic milieu is marginalised within MH discourse, and nursing practice and psychiatric programs rely on the biomedical treatment paradigm, which supports Fairfax (2016) and Browne et al. (2012). These studies appear to indicate that the therapeutic milieu is experienced by staff and patients as non-conducive to the cultivation of the therapeutic relationship in AMHS. Although this research addresses what is desired in AMHS, the body of literature to date has not explored in depth how HCP navigate the complexities and contradictions embedded in the MH system. While we can be mindful of cultural nuances (these studies were conducted in France, USA, and Canada respectively), consideration of systemic power and control may be embedded within the UK perspectives of MH professionals, patients, and their families. These studies are relatively small qualitative studies and are not generalisable in and of themselves. However, they do support each other's findings and indicate that further investigation is warranted within the UK. This is not being proposed to necessarily elicit policy change or challenge the system, but to develop an awareness of these barriers to the therapeutic relationship, to open up engagement with biomedical perspectives and work with it.

2.5.2. The social construction of the importance of the therapeutic relationship

From a social constructionist perspective, a concept is known and negotiated through the action of talk, which is coloured by historical, cultural and personal lenses (Willig, 2013). Gilburt et al. (2008) conducted a UK-based, user-led study investigating relationships in MH care, using thematic analysis on nineteen interview transcripts. They concluded that during admissions to AMHS, the overarching theme of the interviews were regarding relationships. Patients experienced positive relationships consisting of; communication, cultural sensitivity, and the absence of coercion, which created a safe and trusting initial bond with staff. They also found that ineffective communication, staff coercion and violent actions, or their ineffectiveness in preventing violence inhibited the creation of positive relationships. Critically, this qualitative, independent research was

commissioned by the National Institute for Health Research Service Delivery and Organisation Programme and claims to contain the views of the authors, and no other organisation. Priebe and McCabe (2006) review suggest that mutual conditioning takes place within therapeutic interactions, in that being calm, helpful and sensitive to patient's needs would facilitate a good relationship. Priebe and McCabe (2006) propose that the therapeutic relationship is a "socially constructed institution" (p.70) in which diagnoses, treatment plans, and interventions are discussed and negotiated, and in itself, is curative. Additionally, drawing from systems theory, they argue that the patient's family and psychiatric setting co-construct this concept and assert that the therapeutic relationship and the psychiatric setting are "mutually constructed realities" (Priebe & McCabe, 2006, p.70). This paper does not offer a clear synthesis of all previous research, and mainly offers a summary of the author's work and theoretical underpinnings of their work. However, this concept is of particular interest to the current research and may indicate that a social constructionist perspective be adopted to explore this topic. Counselling psychology recognises the need to be critical and methodologically pluralistic (Henton, 2016); hence other viewpoints will also be explored.

2.5.3. Service users' needs

The HCP-patient relationship requires analysis from the patient's perspective and would seem beneficial to ascertain what the service-user experiences are. An independent charity enquiry by Mind (2011) into AMHS in the UK, summarised the perspectives of service-users, their families, and staff working in NHS AMHS. Overall, a varied range of positive and negative experiences was reported. The inquiry highlighted four areas for commissioners, provider organisations, and staff teams to focus on: commissioning for people's needs, choice and control, reducing the medical emphasis in acute care, and humanity. It was concluded that service-users want humanistic qualities to be incorporated in their care, including warmth, empathy and respect, which necessitates staff training in disturbing behaviour, its prevention, de-escalation, and management, with humane values (Mind, 2011). This independent charity-run enquiry was used to offer an impartial evaluation of this setting highlights that AMHS adopt a humanistic approach; however, the experiences of patients do not always reflect this. In not addressing the systemic issues outlined above, this inquiry is in danger of positioning AMHS and its staff as uncaring, instead of needing support to provide a humanistic approach from within this challenging, diagnosis-based system of care (McSherry et al., 2015).

Critically, the charity Mind is not regulated by a Health organisation and this evaluation and the findings are not subjected to a rigor of a research methodology. Therefore, it is necessary to view this data in this light. Nonetheless, some research has found evidence of unsympathetic staff behaviour, which also warrants further evaluation.

2.5.4. A 'them and us' attitude

Wood and Pistrang (2004) address potential power dynamic issues in their thematic analysis of patients' and nurses' accounts of an AMH ward in London, UK. Ten themes were found, and organised into three clusters; patient interactions, staff behaviour and attitudes, and non-consensual treatment. Patients reported that their own and others' psychological functioning left them feeling unsafe, and both staff and patients reported feeling threatened and vulnerable due to patient-patient and patient-staff violence. This could be physical, verbal, non-verbal, and sometimes sexually charged. Furthermore, feelings of vulnerability and powerlessness were elicited from non-consensual psychiatric treatment, such as; seclusion, restraint, and forcible administration of medication were stated as provoking a sense of uncertainty about the staff. Chiefly, "a 'them and us' attitude was one way in which feelings of intimidation seemed to be fostered" (p.23), which was implicitly, and explicitly expressed in both patient and staff accounts (Wood & Pistrang, 2004). Nevertheless, patients also reported positive experiences such as developing supportive friendships with fellow patients and feeling the sense of being understood by another person, which were regarded as meaningful during their stay in hospital. Wood and Pistrang (2004) concluded that patients wished to be empowered, but nurses were afraid to let this happen for fear of getting hurt, which created a dilemmatic conundrum for nursing staff. This research highlights the conflictual tensions and delicate balance between issues of risk and safety, and humanistic treatment that appear to be woven into AMHS culture and appears to require continuous assessment and management. In assessment of this study, the sampling bias in the discussion highlights the limitation of qualitative studies in that they can attract people, both staff and patients, who may have experienced adverse experiences in AMHS. Nonetheless, this study offers value in that it offers a qualitative assessment of the participants' experiences.

2.6. Mental health staff and the therapeutic relationship

2.6.1. Staffs' needs

Further research has identified interpersonal factors that negatively affect the therapeutic relationship, such as reduced compassion and goodwill in staff, and a loss of autonomy and freedom in patients (Walsh & Boyle, 2009; Knowles et al., 2015; Höfer et al., 2015; Sweeney et al., 2014). Nurses and patients agree that the therapeutic relationship should be humanistic and patient-centred and that more time is required for its development on psychiatric wards (Moreno-Poyato et al., 2016). However, nurses have attributed these interpersonal challenges to a loss of job satisfaction, a lack of organisational support, and reduced motivation, indicating that they are burned out and in need of supportive supervision (Moreno-Poyato et al., 2016). It would appear that time and resource limitations impact a holistic approach to the care that nurses provide, and despite HCP and organisations agreeing about what is required, this is challenging to implement in practice.

Furthermore, a lack of literature exploring nurses' perceptions of the "concept of the therapeutic relationship as a whole" (p.748) has been identified (Moreno-Poyato et al., 2016). This paper offers an invitation to build on this research with further qualitative study. Synthesising opposing tensions is a core value of counselling psychology (Woolfe, 2016), and as such could address the dialectical opposition between being with the patient therapeutically and the systemic barriers to creating and maintaining this care, and therefore fill this identified gap in the research literature.

2.6.2. Nurses experiences of aggression

With an interest in the supervisory role that psychologists play in AMHS for ward staff, a focus on nurses' experiences of this setting will now be explored. Feeling a lack of safety has been reported by both nurses and patients (Wood & Pistrang, 2004; Moreno-Poyato, et al., 2016), and nurses concerns have been investigated using quantitative analysis to assess their experiences of inpatient aggression (Nijman et al., 2005). With a quantitative design, and across this sample of 154 questionnaires, 80-90% of nurses reported verbal abuse and threats, 68% reported experiences of sexual harassment and intimidation, and 16% reported experiences of severe physical violence. Amongst their findings, sick days were attributed to experiences of physical violence, sexual

harassment and intimidation were experienced by younger staff members, male staff were more likely to report severe physical violence, unqualified staff reported receiving more passive-aggressive behaviour, and staff working with involuntary patients reported higher frequencies of aggression. This quantitative data offers more generalisable results that support the previously mentioned qualitative findings and can inform further study.

Aggression could be considered a significant interpersonal challenge of working in AMHS and necessitates exceptional staff training in defusing and managing these situations. Evidence-based interventions have been taken to ensure safer ward environments. For instance, the Safewards model (Bowers, 2018) has been developed from previous studies exploring various aspects of AMHS. Six precipitating factors are presented that can trigger containment and/or conflict; the staff team, the physical environment, outside the hospital, the patient community, patient characteristics, and the regulatory framework. The Safewards model is a systematic strategy offered to promote safety for staff and patients, which has real-life implications for nursing practice. Similarly, Jenner (Bright, 2006; 2009; Star Wards, 2017) has developed a practical application to ensure staff and patient safety, build therapeutic nurse-patient relationships and develop a person-centred approach for AMHS. These initiatives have shown that aggression can be tackled without the use of conflict, restraint, and medication, articulating a move towards person-centred care, also advocated by counselling psychology. Further practice-based research could offer evaluation for this approach and potentially broaden their application. However, aggression is not the only barrier to developing a therapeutic relationship.

2.6.3. The therapeutic relationship is hidden

Pazargadi et al. (2015) analysed Iranian nurses accounts using qualitative content analysis and discovered an overarching theme, "the therapeutic relationship in the shadow" (p551). This theme suggests that the therapeutic relationship holds primacy, but is trumped by biomedical treatments and interventions, due to time restraints and perceived quicker outcomes. These data were divided into three themes that addressed the individual and organisational barriers to the therapeutic relationship, which support the research presented thus far. Nurse-related barriers included; "'negative personal characteristics,' 'work exhaustion', 'inadequate skills', 'pattern-taking', and

'negative attitude of nurses towards nurse-patient relationship'" (Pazargardi et al., 2015, p.553). Patient-related barriers included; "'patient's lack of knowledge' and 'failure to communicate with others.'" (p.554), and organisational barriers included; "'manpower shortage', 'large number of patients', and 'work overload'" (Pazargardi et al., 2015, p.554). Although this paper appears to have created detailed categories of the barriers to the therapeutic relationship, it does not suggest a direction for further research and does not address the limitations of the research. However, this study could inform further research.

Evaluating these previous research studies, it may be feasible to explore this topic from a counselling psychology perspective with a focus on how AMH staff talk about and make sense of their therapeutic relationships with patients. Specifically, how they use discourse to construct their professional identities and make sense of humanistic working within a UK/NHS context. However, it would be prudent to hold some consideration for the cultural differences that may be apparent in a UK study.

2.6.4. The good therapeutic relationship

Using grounded theory, Scanlon (2006) explored nurses' perspectives of how they develop therapeutic relationships. She found that nurses felt that experiential and intuitive learning were important to the development of the therapeutic relationship. The ICS theoretical model (Teasdale & Barnard, 1993) would conceptualise this as knowing/learning through the implicational subsystem, which is also considered the subsystem concerned with relating to others; a way of knowing the world through the "felt sense", (Clarke & Nicholls, 2018, p.4-5). Furthermore, nurses identified that their attitudes towards patients affected the therapeutic relationship, and that good use of; boundaries, respect, listening, self-knowledge, authenticity, empathy, good use of humour, and having a non-judgemental attitude all contributed to building positive therapeutic relationships (Scanlon, 2006). This was supported by Dziopa and Ahern (2009), who defined nurses' therapeutic relationship from existing literature, and identified nine constructs; conveying understanding and empathy, accepting individuality, providing support, being there/being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries, and having self-awareness. Dziopa and Ahern (2009) also identified differing nursing styles; "equal partner, senior partner, and

protective partner" (p.14), and address the qualities, advantages, and disadvantages of each style. These papers focus on the qualities of therapeutic nursing, Scanlon (2006) alludes to this being achieved through intuitive and experimental learning, and arguably these interpersonal qualities can be best honed through practical experience and mentorship. Although this has implications for what junior nurses experience, considering that there can be a mix of both positive and negative placement examples, however, this study lacks insight from another HCPs view of this topic.

It has been shown that nurses incorporate interventions within the therapeutic relationship, such as motivational interviewing, supportive counselling, living skills, helping with housing needs, clinical supervision, narrative therapy, transactional analysis, and prescribing medication (Browne et al., 2012), which illustrates how interventions can incorporate an element of being with patients, and adhere to Rogerian qualities of the therapeutic relationship. Further studies have explored specific nursing qualities such as genuineness (Van den Heever et al., 2015), and helping patients who self-harm (Tofthagen et al., 2014), also supporting the theoretical framework of person-centred care (Rogers, 1967/1986), which details the use of empathy, listening skills, and unconditional positive regard. This practice-based evidence shows that the concept of the therapeutic relationship is challenging to define, operationalize, and study, and perhaps in danger of being undervalued (Browne et al., 2012), however, nurses devote themselves to finding creative ways of maintaining its ubiquitousness in this setting, and this is worthy of further investigation.

2.6.5. The cultivation of the therapeutic relationship

Delaney et al. (2017) propose a model of engagement that could help develop person-centred qualities and increase the amount of time that nurses spend with patients in AMHS. They drew from Peplau's interpersonal relations model of nursing and critiqued that this model does not address "the way energy and information flow between two persons" (Delaney et al., 2017, p.635). They outline a program enabling the nurse to connect and see the meaning in the patients' lived experience through an "empathic bridge […] that cultivates the caring, non-judgemental, compassionate climate" (Delaney et al., 2017, p.636-637). They advocated that interpersonal engagement be revitalised to help nurses support patients in their recovery and suggest that further research be conducted exploring what nurses know about the therapeutic relationship and engagement work. Delaney et al.

(2017) and Pazargadi et al. (2015) argue that the time restraints and resource limitations placed on nursing staff suggest that they are taken-for-granted. Indeed, some papers suggest that the nursing role, along with the concept of the therapeutic relationship, has been marginalised by the ideological system (Sobekwa & Arunachallam, 2015; Thibeault et al., 2010) represented by the solution-focused, evidence-based, economic-driven paradigm that forms the foundations of the National Institute of Health and Care Excellence (NICE) guidelines (McSherry et al., 2015), and the NHS (Fairfax, 2016). Due to the Payment by Results (PbR) commissioning structure of the NHS, service users are categorised into diagnosis-specific super-clusters and sub-clusters, to ensure that people receive the most appropriate, evidence-based care for their needs (Fairfax, 2016; NICE, 2018a). Patient experiences are considered, and person-centred care is incorporated into the guidelines (NICE, 2018b; 2018c). However, NICE (2018b; 2018c) do not explore the discrepancies that exist between biomedical and relational paradigms of care, the challenges in working therapeutically in AMHS, nor the mixed experiences of patients and nursing staff. Counselling psychology is a discipline that embraces "between-ness" (Henton, 2016, p.137) and toleration of dissonance, therefore exploring this through the lens of counselling psychology could add a greater awareness of how the therapeutic relationship is negotiated in practice.

2.7. Perceived effects of diagnosis on the therapeutic relationship

Shattock et al. (2017) performed a systematic literature review, analysing data with a narrative synthesis approach, regarding the therapeutic relationship with people experiencing psychosis or schizophrenia. The review found that many studies used the Working Alliance Inventory-Short Form (WAI-SF; Tracey, 1989) to assess the therapeutic relationship between HCP and the person experiencing psychosis. Shattock et al. (2017) found positive outcome measures were associated with positive measures of the therapeutic relationship, especially where trauma was experienced by the patient. They advocate consideration of the therapeutic relationship and found that genuineness, trustworthiness and empathy were therapist attributes associated with a positive therapeutic alliance and reduction in symptomatic outcomes, as well as reductions in rehospitalisation, medication use and self-esteem (Shattock et al., 2017). This review concluded that larger longitudinal studies using standardised measures would be required to detail the causal relationship between the therapeutic

relationship and outcomes. This review offers a detailed systematic review of the literature studying the therapeutic relationship with people experiencing schizophrenia and related psychoses.

2.7.1. Alternative perspectives on diagnosis

Douglas (2016) states that diagnosis is "a medical narrative to psychological difficulties" (p.162), and Woolfe (2016) defines diagnosis as being rooted in a positivistic epistemological position, viewed in dichotomous terms of health and illness. Although this can be a useful tool, the limited definitions miss the richness of the person's personality and psychology (Evans, 2007). Larsson et al. (2012) found that the way counselling psychologist constructed the concept of diagnosis affected their way of working with patients and clients. Counselling psychologists are obliged to challenge pathologizing views (British Psychological Society [BPS], 2005), and do not diagnose. Rather their role is to formulate the individual's experiences in a collaborative, person-centred fashion (Douglas, 2016), although this is not exclusive to counselling psychology alone (Fairfax, 2016). However, an understanding of the predominant biomedical perspectives of certain diagnoses such as schizophrenia (Larsson et al., 2012), and other diagnoses (McSherry et al., 2015) is necessary to fully grasp the tensions between the person-centred and biomedical positions prevalent in the field of MH care.

Evans (2007) offered a psychodynamic theoretical frame to understand how the therapeutic relationship can be utilised through countertransference. It is recognised that nurses spend a lot of time with patients and require support to do this job well via supervision groups, to aid understanding of psychosis from a relational, psychodynamic perspective. She offers anecdotal case studies to posit that the psychodynamic perspective can propose an alternative to the biomedical position, by offering an awareness of possible defence mechanisms, enlightening nurses to counter-transference that may corroborate with patient's rationalization and emotional life, validate their feelings and gut reactions and aids nurses to help the patient make sense of their experiences. This article does not offer generalisable evidence but was brought into this review as it contributes to alternative perspectives that are not as readily quantifiable, such as psychodynamic theory.

The CCC approach also offers an alternative to a diagnostic perspective by normalising the commonality amongst all humans to experience alternative states of mind and draws from Teasdale

and Barnard (1993) established cognitive model. For example, a psychotic episode could be described as an "'unshared reality' for the transliminal [experiences] and 'shared reality' for the [experience congruent with] consensus" (Clarke & Nicholls, 2018, p.126), and is precipitated by high levels of arousal. Moreover, this approach advocates a "both/and" (Clarke & Nicholls, 2018, p.130) outlook to their experience (as opposed to the dichotomous either/or mindset prevalent in biomedical discourse), empowering the person to accept, as opposed to feeling shame/sense of wrongness about their MH. These alternatives to diagnosis are based on theoretical models, which, it could be argued are unable to be verified directly. However, they offer something refreshing to perspectives within AMHS, reflecting both a disease/biomedical model as well as relational and person-centred approaches.

2.7.2. Diagnosis impacts how the patient is viewed

The concept of diagnosis has been shown to affect the way HCP interact with people who are classed as possessing personality disorders (Lingiardi et al., 2005). Lingiardi et al. (2005) performed non-parametric statistical analysis, Spearman's Rho, and found that the low alliance scores (California Psychotherapy Alliance Scale; CALPAS, Gaston & Marmar, 1993) were associated with high dropout rate in psychological therapies. They also concluded that cluster A patients (paranoid, schizoid and schizotypal) found the therapeutic alliance more challenging, which was considered an effect of their beliefs that people are generally hostile and threatening, and hence possess a need to withdraw and detach from others. Cluster B patients (antisocial, borderline, histrionic and narcissistic) were gauged by the therapist more negatively, and patients reported impaired trust and interpersonal relationships. Cluster C (anxious, fearful) patients were rated more optimistically by therapists. This research uses quantitative evidence to verify the importance of the therapeutic relationship between HCPs and people experiencing psychosis and implies that the patients' intrapsychic presentation and the HCPs concept of the diagnosis impact the therapeutic relationship.

Pounds (2017) reviewed the literature from nursing, psychology and social cognitive theory perspectives to conceptualise how patients with a diagnosis of schizophrenia may impact the therapeutic relationship with nurses. Five social cognitive dysfunctions typically found in people diagnosed with schizophrenia were explored, emotional processing, social perception, social

knowledge, theory of mind, and attribution biases. These intrapsychic factors were found challenging to interpersonal interactions, and therefore need to be considered when caring for someone with psychosis/schizophrenia (Pounds, 2017). Furthermore, symptoms of psychosis and paranoia have been found influential in establishing therapeutic engagement (Mitchison et al., 2015). An Analysis was performed on data from forty-four participant interviews, a relatively large sample for this qualitative study. Themes relating to disinterest were; denial of psychological problems, distrust in healthcare systems and psychologists, and low perceived efficacy in therapy, and themes relating to interest were; a desire to build skills, to address (non-psychotic) symptoms, and for the opportunity to build a therapeutic relationship (Mitchison et al., 2015). It could be argued that ward staff, with support from the MDT, are in a prime position to explore pre-treatment engagement work, to challenge negative patient perceptions, and increase interest in therapy by developing therapeutic relationships with patients. Taking into account these positivistic and diagnostic factors of psychosis, these studies add balance to this evaluation and frame this knowledge within the culture of AMHS. Additionally, they highlight the diagnostic, symptomatic factors that could influence therapeutic relationships, and add consideration to potential expectations and assumptions that could be made by both HCPs and patients regarding the diagnosis of psychosis. Critically, it is difficult to ascertain to what extent these perceived intrapsychic factors are due to the diagnosis itself, or the beliefs people hold about them. Nevertheless, HCP are required to work with these factors skilfully by receiving training and support to help them cope well with varying presentations, which has been demonstrated with the following research.

2.7.3. Seeing past the diagnosis

Student nurses' perceptions of developing a therapeutic relationship with anti-social personality disorder (ASPD) patients in forensic placements, was affected by diagnostic terminology (Jones & Wright, 2015). However, this was overcome by the positive influence placement staff had on students' judgements of the diagnosis. Despite the focus of this research being ASPD, rather than psychosis, this could be described as an example of experiential learning through mentorship with more experienced nurses, which could lead to an intuitive understanding of developing therapeutic relationships, as suggested by Scanlon (2006) and Van den Heever et al. (2015). Engqvist et al. (2007) explored strategies that nurses used to help build a therapeutic relationship with women

suffering from postpartum psychosis. Nurse-patient relationships provided basic needs, a sense of security, gave hope, reconnected the patient with reality, and acted as a bridge between the patient and her relatives by informing them about post-partum psychosis; it also aided a partnership between the patient and the rest of the care team (Engqvist et al., 2007). This research suggests that in postpartum MH services, nurses utilise the therapeutic bond to deliver support and interventions. Indeed, the postpartum setting offers a smaller nurse-patient ratio than generic AMHS, possibly enabling more time and resources for patient care, something that has been found lacking in general AMHS.

McMullan et al. (2018) conducted a qualitative study using Interpretive Phenomenological Analysis (IPA) and found that time and staff resources were limited and impacted the experiences of nurses working with voice hearers in AMHS. Themes were discovered that reflected a sense of powerlessness and helplessness that staff feel when working with people who are distressed by hearing psychotic voices. This paper proposed that time be protected for reflective practice to enable staff to feel supported in their work, reduce the prevalence of burnout amongst staff, and provide the staff with tools to reduce their anxiety and increase contact time with voice hearers (McMullan et al., 2018). Additionally, Lawlor et al. (2014) found that paranoia in the therapeutic relationship was prevalent between and within sessions with therapists. These findings support a person-based, radically collaborative approach (Chadwick, 2006), accepting and validating paranoia, as well as being open and authentic, which strengthens therapeutic relationships. Furthermore, the therapeutic relationship can be considered care in its own right and predicts social inclusion through providing a "supportive, optimistic, hope-inspiring relational environment" (Berry & Greenwood, 2015, p.158). These studies have captured how HCP manage their work with various presentations, and support Rogers (1967/1986) notion that the therapeutic relationship is sufficient, and all that is necessary for therapy. However, guidelines recommend a biopsychosocial approach to the treatment of psychosis and schizophrenia (CCQI, 2017; NICE, 2014) also state that "antipsychotic drugs have been the mainstay of treatment of schizophrenia since the 1950s" (NICE, 2014, p.302). The biopsychosocial approach poses a synthesis of medical, psychological and systemic approaches in treatment and recovery. Arguably, the biomedical approach continues to take precedence in managing symptoms of psychosis. However, many of these interventions could diminish a trusting relationship with staff

and fuel a sense of coercion, authoritative and dismissive relationships with staff. These biomedical interventions can complement this when applied with a person-centred approach. How this is implemented in AMHS could be explored further.

Discourse analysis could provide a useful method to explore this as it could capture how HCP use discourses to position themselves within the biomedical and humanistic paradigms of care, and how their talk aids the construction of the concept of the therapeutic relationship with people experiencing psychosis. Larsson et al. (2012) used Critical Discursive Psychology (CDP) to explore how counselling psychologists construct the concept of diagnosis, in particular schizophrenia, and how this affects their work. They found three themes; relating to the individual's experience, the therapeutic relationship – the contrarian subject position, and normalising the experience – the egalitarian subject position. This research concluded that counselling psychologists negotiate their professional identity within a biomedical discourse by; helping the patient find meaning to their psychotic experiences, centralising the therapeutic relationship discourse as an alternative and more ethical to biomedical discourse, as well as emphasising an anti-pathologising position in their role in normalising psychotic experiences over distraction techniques. Although this research is a small, qualitative study and it could be deemed of little relevance to the topics of psychosis and the therapeutic relationship, this study is highly influential to the proposed research as it addresses how discourse of the therapeutic relationship is used within a predominant biomedical environment, and how CDP can be utilised to draw out how language is used to interpret and construct experiences and identities of HCPs.

2.8. Implications for the field of counselling psychology

With a desire to avoid factionalism between psychological professions, it is necessary to state that clinical and counselling psychologists, as well as nurses and patients, share common person-centred values (Fairfax, 2016), as this review has highlighted. However, counselling psychology tends to gravitate more towards process, integration and the utilisation of the therapeutic relationship in therapeutic approaches (Fairfax, 2016) and therefore has a vested interest in promoting research exploring this topic (Milton, 2016). This critical literature review broadens the counselling psychology contribution to therapeutic relationship literature, as well as incorporates the field of

AMHS, and certain diagnoses such as psychosis and schizophrenia, which it currently lacks (Larsson et al., 2012). Counselling psychology also holds an obligation to challenge pathologizing views (BPS, 2005), however, can equally accommodate the target driven, PbR commissioning structure of the NHS, designed around diagnosis and severity of conditions (Fairfax, 2016). Considering counselling psychology is a profession that attempts to synthesize dialectical tensions (Woolfe, 2016), it would seem an ideal discipline to endure contrasting viewpoints such as these, to investigate how nurses, manage therapeutic engagement with patients within this system of care. As such, this discipline may add a unique, and hopefully, more balanced awareness, incorporating a process-based, person-centred approach to the current literature.

2.9. Summary

Establishing a therapeutic relationship with people in acute crisis can be extremely rewarding and challenging, for various systemic, interpersonal, and intrapsychic reasons. Historically, there have always been two opposing views of MH care; the biomedical model and the therapeutic relationship model. The former sits in a positivistic stance positioning the HCP as superior to the patient, and the latter sits in a humanistic stance and attempts to horizontalise the professional-patient relationship. The literature featured in this critical review has been chosen with the intention to highlight the conflict between biomedical and humanistic ways of working. It has been found that biomedical interventions are quicker, less costly, and potentially less risky, however, can be perceived by HCP and patients as dehumanising. The literature also highlights further systemic challenges, time restraints and resource limitations leave less staff on wards to offer time for patients and are also associated with staff sickness and burnout. These challenges are understood and have influenced interventions and policies that emphasise the therapeutic relationship as pivotal in the care provided in AMHS. However, the mixed experiences of patients and nursing staff require further exploration to gain a greater awareness of how the therapeutic relationship is negotiated in practice.

The therapeutic relationship has been found to be important in creating meaning for patients. It has been reported that they value good communication, authenticity, trust, safety, being treated as an equal and as a person. However, they also want practical solutions, and to feel empowered in finding their way through their MH concerns. Further research has explored nurses' accounts and

concluded that "the therapeutic relationship [is] in the shadow" (Pazagardi et al., 2015, p.553). Despite feeling taken-for-granted and marginalised, nurses have found value in developing and maintaining therapeutic relationships with patients, through experiential and intuitive learning. They have developed creative ways of being with the patient, as well as offering practical solutions by honing their interpersonal skills and incorporating interventions into their therapeutic encounters. However, little is known about this process.

Within the biomedical understanding of various diagnoses, intrapsychic factors have been identified as contributing to interpersonal barriers of the therapeutic relationship. Additionally, people with a diagnosis of psychosis/schizophrenia have been found to possess social cognitive dysfunctions that can limit their interpersonal skills. Nonetheless, HCP working with people living with symptoms associated with this diagnosis find ways to achieve a trusting, authentic, and radically collaborative approach to their care, but they can only be expected to do this with protected time, resources, training, and support. Therefore, the research question for this project will explore; how do HCP use discourses to construct and make sense of their therapeutic relationships with people experiencing psychosis in AMHS?

This research aims to:

- explore MH staffs' use of talk to construct their experiences of therapeutic relationships with people experiencing psychosis within AMHS.
- increase awareness of how discourse resources and processes (Edley, 2001; Horton-Salway, 2007) frame and construct experiences of therapeutic relationships in AMHS.
- add to existing knowledge of how therapeutic relationships are created and maintained despite barriers, such as; the patient's level of distress and the time-restricted, resource-limited clinical environment of the National Health Service (NHS).
- provide insight into what staff need from counselling and clinical psychologists, who provide reflective practice and supervision to ward staff.
- identify how this research may offer insight into how counselling psychologists might be able to support acute staff in their development of therapeutic relationships with people experiencing psychosis through supervision and reflective practice groups?

- represent the counselling psychology voice, which is underrepresented in tertiary MH care.

Chapter Three: Methodology

3.1. Epistemological position

This research will utilise a social constructionism epistemology, which reflects the Critical Discursive Psychology (CDP) methodology. CDP uses a fusion of Foucauldian Discourse Analysis (FDA) and discursive psychology (DP). This enables an analysis of the macro, top-down discourse resources, as well as micro, bottom-up discourse processes (Horton-Salway, 2007; Wetherell, 1998; Edley & Wetherell, 2001) and addresses the weaknesses in both types of discourse analyses.

Social constructionism "conceptualises language as a form of social action that constructs versions of reality" (Willig, 2013, p.172), assumes that knowledge is situated in social, cultural and historical context, and is inseparable from social action (Burr, 2003). Burr (2003) conceptualises social constructionism as a continuum ranging from radical to light. An evaluation of this continuum will aid further understanding of how this continuum relates to the mechanics of the analytical process of the top-down discourse resources and bottom-up discourse processes within CDP. Radical social constructionism is concerned with the influence of external social forces and macro levels of analysis of discourse, which captures institutional and social powers that can impose upon the individual. This radical social constructionist approach is necessary for this research as it acknowledges the MH care discourse resources that individuals draw upon from historical and cultural influences and can identify power relations between systems and people. However, it has been argued that this radical position does not acknowledge "pure experience" (Willig, 2013, p.11) or bottom-up discursive processes that individuals use to co-create an MH care culture through the action of talk. In order to reconcile this limitation, Burr (2003) offers the light version of social constructionism, which concerns itself with the idiosyncrasy and agency that individuals may employ to (a) construct their realities, and (b) influence the macro-reality. This epistemologically satisfies the methodological demand of CDP and would ensure the capture of the micro-level of analysis of the bottom-up discourse processes people use to construct their sense-making and subject positioning.

Viewing social constructionism as a continuum, will also acknowledge the participant and researcher interpretations and positions, the fine-grained, micro-level nuances of their discursive actions (Wetherell, 1998), and how participants negotiate the construction of their realities within wider systemic contexts (Willig, 2013). This evaluation has been influenced by previous literature, which positions the therapeutic relationship and the psychiatric setting as socially constructed institutions in which diagnoses, treatment plans, and interventions are discussed and negotiated (Priebe & McCabe, 2006). Further evidence has identified systemic, interpersonal and intrapsychic barriers to the therapeutic relationship in AMHS (Pazagardi et al, 2015), and has validated the historical and current contentions between the biomedical and relational models of care (Historic England, 2018; Quakersintheworld, 2018; Priebe & McCabe, 2006). Alongside this evidence of radical social constructionism, which acknowledges the power of social interaction, structures and institutions, light social constructionist evidence has been found that illustrates how HCPs working within various biomedical settings express creative ways of working with people effectively in a person-centred manner (Jones & Wright, 2015; Scanlon, 2006; Engqvist et al., 2007; McMullan et al., 2018; Lawlor, Hill & Ellett, 2014; Berry & Greenwood, 2015). This indicates that HCPs construct, negotiate and utilise the available discourses to work humanistically within biomedical environments, and therefore the full spectrum, from radical to light social constructionism is justified for this research.

The therapeutic relationship has proved to be difficult to define, measure and operationalize (Browne et al. 2012), and has been studied predominantly using quantitative methodologies and been associated with positive outcomes (Stiles, 2012; Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Horvath et al., 2011; Friedlander et al., 2011). However, little is known about the qualitative "interactive, subjective and dynamic components" (Scanlon, 2006, p.319) and a specific focus on the concept of the therapeutic relationship in AMHS has yet to be studied using discourse analysis. This research project intends to fill this methodological gap in the existing literature. Furthermore, counselling psychology is a profession that aims to challenge pathologising views (BPS, 2005), and there is a predominant biomedical understanding of certain diagnoses such as schizophrenia (Larsson et al., 2012). Acknowledging this diagnosis-orientated viewpoint is necessary to fully grasp the tensions between the person-centred and biomedical positions prevalent in the field of MH care. This

research intends to take a qualitative, social constructionist approach to focus on how AMHS staff use discourse to construct and make sense of therapeutic relationships with people experiencing psychosis.

3.2. Other methods considered

The concept of the therapeutic relationship has a breadth and depth of theoretical frameworks and has previously been explored using phenomenological methods (Shattell et al., 2007; Thibealt et al., 2010; McMullan et al., 2018), and grounded theory (Sun et al., 2006; Scanlon, 2006; Johnson & Delaney, 2006; Vuckovich, 2009; Farrelly et al., 2015). Staff and service users' experiences in AMHS have also been studied qualitatively using discourse analysis (Benson et al., 2003; Crawford et al., 2013; Moon, 2000). However, a specific focus on how staff make sense of the concept of the therapeutic relationship within AMHS has not yet been studied using discourse analysis, nor has it been explored in this setting from a counselling psychology perspective. Although there are many barriers to their work, Chapter Two has also identified that AMHS staff tolerate and manage the tensions between biomedical and relational paradigms of care, and this is worthy of further study. This research explores how HCPs use discourse to make sense of their therapeutic role within AMHS whilst working with diagnosis, specifically psychosis when unshared realities are part of the experience. The therapeutic relationship has been previously researched using grounded theory (Scanlon, 2006), and phenomenological methods (Thibeault et al., 2010; Shattell et al., 2007). However, the therapeutic relationship between AMHS staff and people experiencing psychosis has yet to be implemented using discourse analysis. This method could bring a focus on how the use-of-language as a social action is utilised by AMH staff to construct their approach and ways-of-working.

3.3. Design

The design of this study is qualitative and employs a form of discourse analysis that analyses both discourse resources and processes, addressing how language is both utilised and created to construct meaning and sense-making of the research topic within professional roles, and health care institutions.

3.4. Method of analysis: Critical discursive psychology

Several methods of discourse analysis have emerged within psychological research during the turn-to-language movement in the field (Parker, 1992). However, a branch of discourse analysis, known as Critical Discursive Psychology (CDP; Potter and Wetherell, 1987; Wetherell 1998; Horton-Salway, 2007; Edley & Wetherall, 2001; Reynolds & Wetherall, 2003) has been chosen as the most appropriate method for this project. As described above, this method is described as a fusion of Foucauldian Discourse Analysis (FDA) and discursive psychology (DP), which enables an analysis of the macro, top-down discourse resources, as well as micro, bottom-up discourse processes (Horton-Salway, 2007; Wetherell, 1998; Edley & Wetherell, 2001). CDP could also increase awareness of how discourse resources and processes frame and construct experiences of therapeutic relationships in AMHS and add to existing knowledge of how humanistic ways-of-working are negotiated despite barriers, such as; the patient's level of distress and the time-restricted, resource-limited clinical environment of the National Health Service (NHS).

3.5. Recruitment process

Potter and Wetherell (1987) state that the validity of methods used to analyse discourse is not reliant on their sample size, nor sample homogeneity. CDP focuses on how discourses are constructed between individuals within a social environment and to explore how acute staff co-construct their understanding of the therapeutic relationship through talk with colleagues, questions that explore how staff talk between each other about therapeutic relationships in AMHS with people experiencing psychosis will be included in the interview schedule. Much research has been conducted using nursing staff as participants, however, there is no research to date exploring the counselling psychologists' voice in this setting. With an interest in understanding how counselling psychologists may provide supervision and reflective practice groups to AMHS nursing teams, a sample incorporating both counselling psychologists and nursing staff will attempt to capture how both professions use discourses to construct and make sense of their therapeutic relationships with people experiencing psychosis in AMHS. This with enable a deeper understanding of interprofessional dynamics that may impact this supportive relationship.

The inclusion criteria included; registered and trainee MH nurses, qualified and trainee counselling psychologists, all currently working or have worked in AMHS for longer than six months, aged between 18 and 65, and have had a caseload that includes people experiencing psychosis within AMHS. The sample incorporated more experienced and less experienced HCPs, in order to explore how discourses may vary between levels of clinical experience. The exclusion criteria included staff who have experienced symptoms of stress or burnout due to working in AMHS (to minimise the concern of ethical issues).

On the advice given via email communications with the Health Research Authority (HRA, 2018; Appendix A), NHS ethical approval was not been deemed necessary, as staff were recruited and interviewed outside of NHS premises and outside of NHS staff contractual hours. Therefore, posters (Appendix B) were distributed outside of NHS premises, including social media (such as Facebook, LinkedIn and Instagram) in order to expand interest in the project, and snowball sampling was also utilised to increase the number of potential participants.

Potential participants were able to contact me via my academic email, over social media or over the phone to ask questions about the research or to receive the participant information sheet (PIS; Appendix C), and to arrange a mutually convenient time to sign consent forms (Appendix D) and attend an interview.

It was considered that the recruitment process may possess potential challenges, such as potential participants lacking interest in my research project and time to participate in an interview. Ward staff I worked with in my AMHS placement all expressed great interest in this research topic, and this was also reiterated by participants that came forward. However, with careful consideration to BPS (2014) guidance regarding the maximisation of benefit and minimisation of harm and balancing the costs to the participants with potential societal benefits, an acknowledgement that the time they have given to the study has been valued with be exercised by offering a £10 Amazon voucher.

3.6. Participants

Nine participants contacted me expressing interest from the poster advertisement on social media and participant information sheets and consent forms were administered on request. Out of

these participants, six signed the consent form and took part in an interview. The interviews ranged in length from forty minutes to one hour and twenty-five minutes. Cathy (pseudonym) was a qualified counselling psychologist who, at the time of interviewing, had 3 years' experience working in AMHS. Lara (pseudonym) was a 2 years' post-qualified MH nurse who currently works in AMHS. Sarah (pseudonym) was a nine-month post-qualified MH nurse, also currently working in AMHS. Freya (pseudonym) was a final year trainee counselling psychologist, who had previously worked in AMHS in Egypt as an assistant psychologist. Diane (pseudonym) was also a final year trainee counselling psychologist, with current experience working in AMHS as a Band 4 MH Support Worker. Valerie (pseudonym) was a newly qualified MH nurse, who previously worked in AMHS as a student nurse and currently works in an acute inpatient eating disorders service with some patients experiencing psychotic symptoms.

Table 1

Table of participants using their given pseudonym, profession, experience details and source of recruitment

Participant	Profession	Experience in AMHS	Recruited via
Cathy	Qualified Counselling Psychologist	Current	Counselling psychology Facebook group
Lana	Registered MH Nurse	Current	Nursing Facebook group
Sarah	Registered MH Nurse	Current	Snowball sampling
Freya	Trainee Counselling Psychologist (3rd year)	Previous	Counselling Psychology Facebook group
Diane	Trainee Counselling Psychologist (3rd year)	Current	Counselling Psychology Facebook group
Valerie	Registered MH Nurse	Current	Nursing Facebook group

3.7. Ethical considerations

Ethical approval was obtained and permission to conduct this doctoral research project was granted by London Metropolitan University Research Committee (Appendix E). In accordance with BPS (2014; 2018), participants' safety was ensured by considering their psychological and physical

health, values and dignity, throughout all times from the first contact through to the analysis of data and write-up. In order to acquire informed consent, participants were required to read the PIS and sign the consent forms prior to the collection of data to ensure they were aware of all their rights and were willing to take part in the proposed research. This was done electronically for participants who were taking part in Skype interviews. Debriefing participants was not necessary as they were informed of the nature of research prior to signing consent forms. However, it was acknowledged that some participants may be sensitive to discussing their nursing role and find the topic upsetting. If they expressed a need for additional support or guidance, or if I observed any signs of distress, assistance would have been arranged in accordance with the distress protocol (Appendix F), however, no participants required such interventions.

3.8. Data collection and materials

Individual semi-structured interviews were conducted with participants. Five interviews were conducted using Skype telecommunication software and one interview (Diane's) was conducted in person. The length of the interviews ranged between forty-five minutes and one hour and twenty-five minutes. The interviews yielded rich, in-depth data regarding how trainee and qualified nursing staff and counselling psychologists construct the concept of the therapeutic relationship in their work. This method of data collection was justified due to the qualitative, social constructionist and critical realist synthesis (Horton-Salway, 2007; Wetherell, 1998), which include linguistic, poststructuralism and ethnomethodological roots (Horton-Salway, 2007; Wetherell 1987).

Data collection from focus groups was also considered as this could have added a breadth of understanding of how frontline staff co-construct the concept of the therapeutic relationship through social interaction with their colleagues and peers. Unfortunately, due to the scale of this research project focus groups were unable to be organised and implemented. However, in an attempt to compensate for this, I brought myself and my experience to each interview as an HCP who has also worked in AMHS with people experiencing psychosis. This was established in the pre-interview discussions and an attempt was made to facilitate some intersubjectivity within the interview in order to add some ecological validity to the research, in the absence of focus group data collection.

It was necessary to employ an interview schedule (Appendix G), consisting of a number of questions and prompts that aided the interviewer during the interviews. In accordance with discourse analysis epistemology, of which CDP falls under, Potter & Wetherell (1987) suggest that consistency within an interview schedule is only important in so far as it may "identify regular patterns in language use" (p.164). Therefore, variability in the interview schedule occurred in response to participants' process in order to enable them to draw from broad, yet comparable interpretive repertoires, to construct their professional subject positions, and illustrate their meaning-making of therapeutic interactions with people experiencing psychosis in AMHS. Transcription was performed using templates laid out by Potter and Wetherell (1987) and included a version of Jefferson (2004) intonation coding (Appendix H).

3.9. Data analysis

Potter and Wetherell (1987) offer a ten-stage process to discourse analysis but also warn that prescriptiveness is often unhelpful, as discourse analysis skills are learned experientially during the process. Reading and rereading of transcripts, in order to familiarize oneself with the data, is required before coding begins (Horton-Salway, 2007; Potter and Wetherell, 1987; and Edley, 2001). Coding is described as "pragmatic rather than analytic" (Potter & Wetherell, 1987, p.167), not necessarily involving the categorisation of codes but to create a "body of instances" (p.167), which may include vague or ambiguous utterances. Potter and Wetherell (1987) advocate a focus on detail (rather than gist), and an acknowledgement of contradictions and vagueness. A large part of the analysis involved an exploration of my own relationship with the data; as Potter and Wetherell (1987) advise, the researcher must ask themselves "Why am I reading the passage in this way?" (p.168). Phases of analysis involve (a) finding patterns of variability and consistency, locating differences and similarities in the data, and (b) finding functions and consequences, which satisfy the assumption within discourses analysis that language is used to fulfil a function (Potter and Wetherell, 1987).

Goodman (2017), Horton-Salway (2007), Edley (2001), Reynolds and Wetherell (2003), and Edley and Wetherell (2001) provide examples of data analyses using CDP method, involving a focus on; interpretive repertoires, subject positions and ideological dilemmas.

3.9.1. Interpretive repertoires

Interpretive repertoires can be described as "building blocks" (Edley, 2001, p.198) of common knowledge, cultural ideas, terms, metaphors that are used to construct explanations, descriptions and arguments (Potter & Wetherell, 1987). They are "discursive devices" (Goodman, 2017, p.143) that are used with the intention to accomplish something in the conversation. In this research, this included participants' shared knowledge, understandings and ways-of-being that were expressed when they talked about their everyday work with colleagues and patients.

3.9.2. Subject positions

Subject positions are closely related to interpretive repertoires when the focus is on the identity of the talker or other's whom they are discussing. These are considered culturally available discourse resources that define a person's identities, which are considered fluid within CDP. Edley (2001) contests that there is an element of agency in identifying with a particular subject position within social interactions that may be evident in the participant's talk. This is contradictory to FDA, which contests that the cultural discourses dictate a person's position (Willig, 2013).

3.9.3. Ideological dilemmas

Ideological dilemmas, a term coined by Billig et al. (1988) describe inconsistencies and contradictions in everyday discourse. Billig et al. (1988) highlight how beliefs and attitudes can be used as "flexible rhetorical resources" (cited in Horton-Salway, 2007, p.62) in order to construct an argument, but possess contradictions and complexities. Previous research has already identified contentions between different MH discourses (Pazagardi, 2015; Priebe and McCabe, 2006; Shattock et al., 2017). Consequently, this research focused on the processes in which HCPs utilised talk to position themselves within and between these discourse resources and how they may hold these dialectical and rhetorical contradictions regarding their meaning-making process and constructions of the therapeutic relationships they made with people experiencing psychosis. The raw coding table that captured the interpretive repertoires, subject positions and ideological dilemmas can be found in Appendix J.

3.10. Reflexivity Part Two: The Researcher's Relationship with the Chosen Epistemology and Methodology

Milton (2016) states that humans are ontologically predisposed to attach, empathise and care, qualities that facilitate relationships, built on an ability to listen to verbal and non-verbal information. In association with the topic of the therapeutic relationship, this aspect of human nature could be considered within biopsychosocial theory that describes an evolutionary adaptation that serves primal, survival needs. Parker (2015) states that theory structures phenomena, which can be conceptualised as a realist ontological stance. He also stipulates that the complexity and inability to control social behaviour dictates a relativist epistemological position. Therefore, it can be concluded that a social constructivist perspective is appropriate to frame the study of the therapeutic relationship. In my experience, and in association with Milton's statement above, the ability to attach, empathise and listen with colleagues and clients is mediated through an ontological ability to attend to discursive actions and environments. This understanding and use of language can play a valuable role in developing therapeutic relationships, and in how we may construct and make sense of those relationships with the people accessing MH services. It could also be considered that an intersubjective exchange influences the way in which we connect with others and is intricately associated with our sense of self and identity, as well as our moral and ethical values towards others. For me, this is encompassed with a sense of integrity towards humanistic values throughout my life and has been brought to the forefront throughout my counselling psychology training.

My personal social constructionist epistemological position appeases an intuitive, felt sense of an, arguably, idealistic relationship with the world as a creative, empowered individual who can shape and adapt myself and the discursive world in order to create a meaningful world. However, a critical realist position was also considered, as this stance would hold and frame this research in the consensual *real world* that encompasses Westernised world views and MH institutions as they function in today's culture. As discussed in Section 2.4, it could be argued that the biomedical, normal-abnormal categorisation of MH has historical roots. However, it can equally be argued that the anti-psychiatry, anti-stigmatising, continuum of human experience that hold the opposing dialectic of MH presentations is also culturally available as discursive resources. Therefore, it was ultimately decided that the social constructivist epistemology was sufficient for this project.

The choice of methodology was challenging with this topic. The therapeutic relationship in AMHS has been investigated from a nursing perspective predominantly using grounded theory, and this would have served as a valuable methodology to explore this from a counselling psychology perspective. I also considered Interpretive Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009). However, due to my observations of the seemingly conflicting ideologies within this setting and the ambiguities between how HCPs are trained, with varying degrees of consideration of biomedical and relational approaches, I predicted that a number of ideological dilemmas could be expressed in HCP's talk. Moreover, when working with a person experiencing psychosis, a diagnosis that has labelled as a severe MH dysfunction and associated with intense medical intervention in its acute form, it was posited that potential ideological dilemmas would be exacerbated.

Part of becoming a counselling psychologist requires trainees to develop an ability to become reflective practitioners and researchers, to be aware of their positions and biases, and to use their reflexivity discerningly in their clinical and research practices. CDP requires researchers to conduct interviews with consideration to the biases and subjectivity, and the researcher's questions are equally open to analysis, as they are considered part of the co-construction of meaning (Potter & Wetherell, 1987). Therefore, CDP offered an opportunity to satisfy this training requisite, and to immerse myself in this project reflexively and reflectively. Focus group interviews would be an ideal medium for any form of discourse analysis in order to analyse how meaning is co-constructed between people. However, this was not advisable due to the time restraints of this research project. Therefore, the analysis of myself within the interview process (and the research process as a whole) could add valuable evidence of the intersubjective nature of meaning-making that CDP can capture.

Chapter Four: Analysis of Findings

4.1. Introduction

Interpretive repertoires were found in the data that captured how counselling psychologists and nurses who have worked in AMHS make sense of the therapeutic relationship in this setting with people experiencing psychosis. Participants drew from several macro-level, top-down discourse resources, which are embedded within MH systems and the wider socio-cultural environment. These discourse resources were reconstituted throughout the action of talk using micro-level, bottom-up

discourse processes, such as rhetorical devices and figures of speech, which constructed theirs and others' subject position. Additionally, contradictions and conflicts between the various discourse resources were identified, highlighting ideological dilemmas in the way they make sense of working in AMHS and with people experiencing psychosis. From this analysis, four interpretive repertoires regarding the therapeutic relationship emerged from the data, which best answered the research question, how do HCPs make sense of the therapeutic relationship with people experiencing psychosis within an AMHS setting?

CDP analysis takes an action-orientated approach, which involved searching for what is being accomplished in participants' talk (Goodman, 2017). The analytic process revealed the therapeutic relationship in terms of both system (what it is) and process (how it is achieved/utilised). The analytic process, and way in which this could be presented, was considered at great length and is explored in more detail in Section 5.11. However, concerning Potter and Wetherell (1987), who advises against prescribed analyses and advocate for a creative and intuitive analytical process, I ultimately decided to present the findings with integrity to my interpretation. This involved nesting discourses within the interpretive repertoires that describe the sense-making of the therapeutic relationship; the discourses are considered part of the interpretive repertoire. Consequently, the interpretive repertoires (left column, Table 2) describe how participants made sense of what the therapeutic relationship is, and the discourses (right column, Table 2) detailed how participants made sense of the actions required to achieve therapeutic relationships with people experiencing psychosis in AMHS.

The extracts for participants' interviews will omit the superfluous or process orientated utterances in their speech. Additionally, some extracts span several lines or words that were not pertinent to the point being made, these will be omitted with [...]. These changes to the original transcript will improve its readability and also better capture the meaning within the talk.

4.2. Interpretive Repertoires

Table 2

List of Interpretive Repertoires and Functional Discourses

Interpretive repertoires	Discourses
4.2.1. The therapeutic relationship bridges the mental health system and the person experiencing psychosis	4.2.1.1. Building trust by aligning with the person's experiences
	4.2.1.2. Managing expectations
4.2.2. The therapeutic relationship as a means to manage psychotic experiences with a boundaried, yet flexible approach	4.2.2.1. Being consistent and boundaried
	4.2.2.2. Being flexible and creative
4.2.3. Meeting the person experiencing psychosis through the therapeutic relationship	4.2.3.1. Being trauma-focused
	4.2.3.2. Making a connection with the person experiencing psychosis - transference and countertransference experiences
4.2.4. The therapeutic relationship is not just between two people – The MDT	4.2.4.1. Professional differences create splitting within the team
	4.2.4.2. Professional diversity creates broader understandings

4.2.1. The Therapeutic Relationship Bridges the Mental Health System and the Person Experiencing Psychosis

Participants used a mix of biomedical and person-centred discourse resources to form a bridge between the MH system and the person. They achieved this by positioning themselves alongside the person's experience to build trust and by defusing negative expectations that the person might have about AMHS. This did not only occur between HCPs and inpatient but also between HCPs.

4.2.1.1. Building Trust by Aligning with the Person's Experiences. Within the data, the word trust was prevalent, and trust was seen as difficult to attain when the person has been sectioned

(detained against their will). A trusting relationship was achieved by balancing conflictual ideological dilemmas and subject positions. In Extract One, Lana expresses how building trust takes a lot of time with someone who has had their *"liberties [taken] away"*.

Extract One.

I think for me it's trust it takes a lot of time to build trust especially when we think of patients who are detained we are we have taken the liberties away from them and in those moments they can't always acknowledge that that may be in their best interests so therapeutic relationships are built on trust mutual respect [...] encourage people that what they're suffering is okay (Lana, line 9-14)

Her statement *"they can't always acknowledge that [being detained] may be in their best interests"*, which perhaps offers a justification for the length of time it takes to gain trust and mutual respect. Additionally, this statement positions Lana in alignment with the rationale for the intervention of detaining, which is justified by the phrase *"in their best interests"*. This is followed by the word *"so"*, offering a reason for *"trust"* and *"mutual respect"* to be crucial qualities of the therapeutic relationship. The statement *"we have taken the liberties away from them"* highlights an ideological dilemma for HCPs who identify with the MH system and therefore a part of it, as Lana illustrates with the pronoun *"we"*, and attempts to build trust with people detained by them. Below, Valerie offers further elaboration on the ideological dilemmas regarding building trust.

Extract Two.

I'm friendly but I'm not your friend and this could be a clear distinction there between being someone that someone can trust [...]if you can be trusted (.) cos I think a lot of people who have experienced being in the mental health system (.) have become a bit disenchanted with it you know maybe we've made decisions as a profession that don't ally with what the person might want in their life (Valerie, line 14-20)

When asked what the therapeutic relationship meant to her, Valerie summarised an ideological dilemma and dual subject position with the statement, *"I'm friendly but I'm not your friend"*. This

employs a rhetorical device known as an antithesis, which presents parallel grammar and two concepts with inverted meanings, which relays the juxtaposition (Literary Terms, n.d) of two subject positions, *"I'm friendly" and "I'm not your friend"*. This could indicate an attempt to integrate the two subject positions by relaying warmth and professional distance. Therefore, the integrated subject position of *"friendly but not your friend"* could be an attempt to present a professional, competent demeanour, eliciting trust and confidence from the patient while balancing the conflictual subject positions. She elaborates on these subject positions by relaying a *"clear distinction [...] between being someone that someone can trust"* (warmth and friendly) and being a member of an MH system and making decisions that doesn't *"ally with [...] the person"* (professional and not your friend). Additionally, the phrase *"we've made decisions as a profession"*, dilutes her agency in these decisions by identifying with the professional group. These discourse processes increase her proximity to the *"trusted"* subject position and bridge the gap between the MH system and the person experiencing psychosis.

Contrastingly, Cathy bypasses the rhetoric around trust and uses person-centred discourse resources to position herself as *"being alongside the person"*.

Extract Three.

being alongside the person [...] (h) I chuckle because I don't know how else to word this but it's to do with the fact that I don't freak the person out so much that they are willing [...] hopefully to <see that> I am alongside them rather than I am yet another professional talking to them (.) or talking at them as:: sometimes people might feel (Cathy, line 18-27)

She chuckles as she finds her choice of words amusing; *"that I don't freak the person out"*. I interpreted this as an expression of finding balance between being too keen to be alongside and too distant. This subject position of *"being alongside the person"* varies from the subject position of *"I'm friendly but I'm not your friend"* in that being alongside does not require defining friendliness but does involve aligning with the person's experiences. She also details a *"professional"* subject position of *"another professional talking at them"*, and its predominance is indicated by the word *"yet"* prior to the statement. Additionally, she uses *"or"* to change her choice of words from *"to*

them" to her preferred *"at them",* accentuating the perceived superior nature of the *"professional"* subject position.

These various subject positions and contra-subject positions reflect a split within the nurses' identity that is not so prevalent in the psychologist's talk. This could be due to the different roles that these two professions hold within the MDT, as it would be highly unlikely for a psychologist to be directly involved in detaining, restraining or secluding the patient and therefore they would not necessarily have to navigate the two opposing subject positions to such an extent. However, both professions are part of the same MH system, and patient expectations that are embedded within MH discourse resources could nevertheless position both professions in non-allying positions. The next interpretive repertoire specifically addresses these expectations in more detail.

4.2.1.2. Managing Expectations. Participants discussed several patient expectations that featured the MH system, staff, and the diagnosis of psychosis, which highlighted discourse resources embedded within MH culture. Participants also utilised many discourse processes in their talk to navigate the expectations, attempting to define their subject position, often in opposition to the system, in order to work with patients in a meaningful way. Contrastingly, patient's expectations *"to be fixed"* (Extract Four) and medication being the answer impacted how HCPs utilised the therapeutic relationship. By aligning with this expectation, HCPs could use the therapeutic relationship to aid medication compliance within a more relational approach. The discourse of medication and medication compliance features across other interpretive repertoires too, but here medication was viewed as an expectation.

Cathy's talk addresses how patients associate being in hospital with being fixed. She also positions herself within this landscape and highlights the positives and negatives of this. This takes some time as she uses various discourse processes spanning from line 74-138, but I have used the most poignant phrases in this extract.

Extract Four.

I wouldn't want to appear that I am there in a sort of talking therapies equivalent to a doctor [...] being able to give a prescription and [...] "here you go, you've come in because something's wrong and here's something to fix you" [...] it is the person's expectations to <be fixed in some way↓>

because they are in a hospital [...] I don't think that people associate hospital settings as being very conducive to having psychological therapy input↑ and I think that itself can be a challenge you almost have to go alongside the person but also be in a position that isn't really alongside them but in a way to inform them that this is the position [...]that it's not about fixing [...]>their expectations are probably< shaped by being told that there's a responsible medical officer for example or responsible clinician and it sounds like you know the person who can prescribe le::ave or the person who can prescribe medication and once the client has that in their <mind> the challenge is for the psychologist "Well, I'm not here to prescribe anything" the challenge is trying to almost <help them to think about> another (.) maybe complimentary approach to your treatment for want of a better word [...] and kind of stay with the values of counselling psychology↑ if that makes sense↑ (Cathy, line 74-138)

Cathy positions herself in opposition to a *"talking therapies equivalent to a doctor"*. This discourse process expresses her disinclination to give the patient the impression that she could *"fix"* them. She continues to explain that the person's expectation of being in hospital is *"to <be fixed in some way↓>*. This reflects a biomedical discourse resource that positions hospitals as places to fix ailments/conditions, and she notes that *"once the client has that in their <mind>"* (she accentuates the word *"mind"* with increased volume and a lengthened speech) it becomes a challenge to promote psychological therapy in AMHS due to people's expectations of being fixed in hospital. This perceived patient expectation positions the HCP as the active healer and the patient as the passive receiver of healing. She manages this contradiction between the patient's expectations and her values by creating an obvious juxtaposition between a position of *"go[ing] alongside the person"* and another position *"that isn't really alongside them"* and offers a *"complimentary approach"* but is alongside her counselling psychology values. This creates an ideological dilemma between two contrasting beliefs concerning the person's expectations of being fixed and to get out of hospital as soon as possible and considering psychological processes that might acquaint the person to the idea that *"it's not about fixing"*, at least not in the way they might expect. Through this ideological dilemma, she bridges the MH system and the person experiencing psychosis by being aware of these challenges whilst simultaneously holding her values as a counselling psychologist, which were interpreted as being person-centred and offering psychological support, even when the person may

be unaware of what she can offer. Her addendum *"for want of a better word"* after the word *"treatment"* hints at a non-pathologising subject position and affirms her complementary, non-medication approach, which was not only found in counselling psychology talk. Nurses also discussed patient's biomedical expectations and expressed discourse resources about AMHS that reflect this. Below, Valerie talks about her subject position as someone who medicates, and also someone who listens.

Extract Five.

when I was in training sometimes I saw a lot of staff who >would just medicate< just medicate just offer medication [...] as if that is somehow you know a chemical quash [...] I don't think that's my job but I also do think my job is to offer medication to someone who is in distress you want to talk to them offer your ears first [...]not to justify my actions as a nurse going to get you medication if that's what you need but to justify my job you know I'm not just a Pez machine for Diazepam [...] that's not- that's not what they hired me for that's not what I spent three years training for [...] if it's needed I'll do it of course I will and then I will offer my ears once that medication has kicked in (Valerie, line 117-139)

Valerie talks about her experiences in training of observing *"a lot of staff"* giving medication as a matter of course, as *"a chemical quash",* again denoting medication as the predominant treatment method. The use of the phrase *"as if that was somehow"* is a discourse process that frames the *"chemical quash"* with some disbelief that this is a productive treatment. The use of the humorous metaphorical rejection of the medicator subject position, *"I'm not just a Pez machine for Diazepam"*, highlights Valerie's distance from this subject position, and she justifies this position by stating that this is not what she *"spent three years training for"*. Instead, she constructs the nurse's dual subject position as medicator and listener and highlights an ideological dilemma by stating that she can offer her *"ears first"*, or after the medication has *"kicked in"*. Adopting this dual subject position of listener and medicator is a discourse process that bridges the MH system and the person experiencing psychosis with both biomedical and person-centred discourse resources and also manages and challenges both staff and patients' expectations to being in AMHS.

4.2.2. The Therapeutic Relationship as a Means to Manage Psychotic Experiences with a Boundaried, yet Flexible Approach

Participants' discourse regarding managing patient's psychotic experiences took both a boundaried and consistent approach, and a flexible and creative style. This combination conveyed a discursive process of both governance and circumventing of ward rules. The main factor that seemed to require this synergistic approach was the unpredictability associated with the person experiencing psychosis. Sarah names unpredictability as something that is difficult to manage within AMHS.

Extract Six.

I think something that is difficult and will always be difficult is the unpredictability with people with psychosis [...] they're in their own mental place and [...] they're more risky which can be difficult to manage (.) never manage unpredictability (Sarah, line 72-75)

This was constructed as a challenging factor in managing people experiences psychosis. The words *"always"* and *"never"* denote a sense of unpredictability being a prevalent factor. Participants discursively danced between taking a consistent/boundaried and a flexible/creative approach to managing unpredictability.

4.2.2.1. Being Consistent and Boundaried. HCPs represent the structured and powerful MH system, and as such appeared to be constructed as holding power over the patient. However, the system's structure can also provide HCPs with reassurance and communality, offering support in a variety of situations.

Extract Seven.

I guess one of the things I like about that setting is the structure↑ [...] you're very closely supervised [...] it gives me structure when I needed to start off as a practitioner it was a holding environment [...] you kind of developed a strong sense of community- sense of being part of something↑ [...] it allowed me to be creative [...] because it allowed me to establish a trust and I saw this patient every other day (.) and I was able to create a very strong alliance and then [...] work with that sort of boundaried structured environment to produce more creative therapeutic techniques↑ (Freya, line 12-29)

Freya talked about her experiences of working in a long-stay AMHS in Egypt. She framed the hospital as providing her with structure at the start of her MH career and referred to it as *"a holding environment".* The use of this repertoire reflects Winnicott's (1990) object relations approach to psychoanalysis that describes the therapeutic relationship as a reassuring and comforting hold analogous to the embrace of mother and child, a safe space to explore emotional vulnerability. Freya described being closely supervised, and the team offered *"a strong sense of community"* and belonging within the AMHS, which possessed greater power that one can belong to and draw strength from. Freya also attributes her creative approach to the *"boundaried structured environment"* of the hospital setting, which helped build *"strong alliance*[s]*"*.

Sarah discussed adopting a boundaried approach through MH staffs' professionality, as opposed to the hospital setting itself.

Extract Eight.

I think being therapeutic also means being professional as well so there are boundaries that shouldn't be crossed (.) they remain therapeutic but there are also things that need to be flexible to make <u>sure</u> that it's still therapeutic (.) it's quite complicated really (Sarah, line 14-17)

She stipulated that *"there are boundaries that shouldn't be crossed"* and also that *"there are things that need to be flexible"*, acknowledging that *"it's quite complicated really".* Her dance between being boundaried and flexible is apparent and suggests an ideological dilemma between creating a sense of too much distance or proximity with the patient, resulting in a loss of therapeutic-ness.

Sarah has worked in a psychiatric intensive care unit (PICU) and also makes sense of the therapeutic relationship by building rapport, being a consistent presence and using grounding statements to keep the person aware of where they are.

Extract Nine.

I don't know it's very difficult I think in the first few days of a psychosis it can be really challenging to build that rapport but I think it's just consistently going to them and saying "I'm here" "We've

taking care of you" reminding them of where they are as well coz sometimes they're confused (Sarah, line 186-189)

Diane also works in a PICU and responded to the question, what type of patients do you find easier or difficult to work with? Below, she described being a consistent presence at the very beginning of patient's stay, which helps in the management of patient's psychotic experiences.

Extract Ten.

she'd come out and just goes for it whoever is nearest would get it so it's that kind of visual and people were very frightened of her staff and the patients because she was so unpredictable [...] so there's definitely that element (.) it's severe and then others who might be very big you know they're- they're turning over tables and every- coz it's PICU we have that a lot of the time [Researcher: but you find those particular patients a little easier because] only because I get to know them at the beginning [...] yeah like even whilst it's all going- even when they're in that stage I can still manoeuvre my way in to build something if that makes sense [Researcher: I've got a sense of you've seen them at their worst] yeah [Researcher: so it's raw] yes that's what I am saying (Diane, line 364-386)

Extract Ten shows a co-construction of meaning between Diane and myself, as together we attempt to make sense of the discourse process. She acknowledges that *"we have that (aggressive behaviour) a lot of the time"* and this is frightening for staff and patients but expresses this in a nonchalant manner. Her lack of apparent fear is understandable in light of a subject position that she declared earlier in the interview; *"I don't tend to be frightened of patients"* (Diane, line 170-171). This position appeared to aid her tolerance of unpredictability, even with violent patients. The strength and consistency within this fearless subject position was also attributed to the familiarity with the patients she nursed in the PICU. She relayed a sense that she was facilitating the therapeutic relationship through a lack of judgement and acceptance of that *"worst"* stage, providing a fearless, authentic genuineness, and a relational mirror for the patient to also see themselves without fear. This co-construction also possessed a sense of Winnicott's (1990) holding within the therapeutic relationship, of a willingness to be with difficult emotions.

4.2.2.2. Being Flexible and Creative. Freya (Extract Seven) attributed her creative approach to the *"holding"* of the AMHS structure. This could be considered an ideological dilemma in that the flexibility to be creative is borne from a boundaried, consistent structure; and both are required for the therapeutic relationship. Similarly, Sarah (Extract Eight) explores the ideological dilemma between being flexible and boundaried. Below, Lana talks about the expectation of *"one-to-one time"* being a sit-down-and-discuss affair, but in *"truth"* this is something more flexible and *"informal"*.

Extract Eleven.

every patient has an allocated person on the ward who they're gonna spend their one-to-one time with and the expectation is that the nurse will spend their one-to-one time with their named patient [..] now in an ideal world my Band six would say ooo a nice one-to-one sit down you've have a chat with them you formulate a plan you've talked about what discharge looks like this this and this (.) the truth is if you got someone that's psychotic it may just be that you are walking up and down the corridor with them as they are pacing [...] I mean I am very informal [...] in my approach but I think probably as someone who is experienced in psychosis it is just about getting those little snippets (Lana, line 990-1008)

The interpretive repertoire *"in an ideal world"* indicates the *"expectation"* of having *"a nice one-to-one-sit down with the patient and formulate a plan"* and preparing for discharge, which represents a structured approach to the patient's care. *"[T]he truth is"* marks the start of another discourse, which Lana constructs as her reality, positioning the expectation as unrealistic. She also positions herself as *"very informal"* and *"someone who is experienced in psychosis"* and advises that *"it is just about getting those little snippets"*.

Valerie's sense-making of working with someone experiencing psychosis involves being creative in managing delusional thinking. Her narrative features a patient who believes she is romantically involved with a male nurse and she expresses how she validates the emotional difficulty without directly challenging the belief.

Extract Twelve.

you don't want to do it to them "Oh don't be daft" or anything like that especially if you know it's a delusion that this person will play out again every single day there isn't really a lot I can say that gonna suddenly erase from their memory these are real emotions real experiences that they have in their physical self they feel that they are connected to another human being they believe something so strongly I can't just erase that with half a dozen words and a puzzle book and a walk around the garden (.) but you can say to somebody "well look it might be a while before you see him again you know but I understand how you feel" or "I'm really sorry you feel that way today what else are we gonna do if you're not gonna get to see him today what else would you like instead?" (Valerie, line 579-597)

Valerie expresses a sense of powerlessness in being unable to *"erase [...] real emotions real experiences that they have in their physical self"*, however she appears to effectively offer validating statements of the patient's emotions. She contradicts herself again when she talks about being unable to *"erase that [belief] with half a dozen words and a puzzle book and a walk around the garden"*, however, proceeds to alleviate the patient's distress with a validating statement and invitation to consider *"what else [she] would [...] like instead?"*. These ideological dilemmas suggest a dissonance between the hopelessness that nothing will help and the effective and therapeutic use of validation and empathy. This discrepancy could highlight a construct that the therapeutic relationship is necessary but not sufficient, however in practice it was adequate enough to manage this unpredictable situation with sensitivity and flexibility.

Diane's narrative features a situation where medication under restraint was avoided by employing creative thinking and a flexible approach. This extract is a response from the question, what factors hinder the development of the therapeutic relationship with people experiencing psychosis?

Extract Thirteen.

so a lot of the time (.) if the patient is going to have IM [...] the team come and she's restrained in her room on her bed and given an injection but there are other ways of doing it (.) creative thinking is quite important [Researcher: so in the wider system sometimes there could be a lack of creative thinking?] yes [...] another Muslim lady a few years ago refusing to take her meds[...] "unless you

say this prayer I'm not taking this medication" right so I thought "well let's just say it it's not the end of the world" [...] so a few of us [...] said it and she said "right you've now all converted to Islam" and she took her medication I mean you do get a lot of classic moments in psychosis [...] I mean things like that are absolutely hilarious (Diane, line 500-518)

Her use of the words *"so a lot of the time"* (line 500) constructs a sense that medication under restraint is a common practice. She stated that creative thinking is required when working with people experiencing psychosis. Her narrative details her way of working with medication compliance by negotiation and allowing the patient to hold some power over the team. This story was told with a humorous tone and described as one of those *"classic moments in psychosis"*. Her discourse process, which combines medication compliance and creative thinking discourse resources shows how she makes sense of managing unpredictability in a flexible, creative and humorous way.

4.2.3. Meeting the Person Experiencing Psychosis Through the Therapeutic Relationship

Participants talked about working with people experiencing psychosis in AMHS drawing from two discourse resources; trauma-focused and biological-focused, and it was found that being trauma-focused enabled more meaningful therapeutic relationships. Additionally, somatic sensations experienced in the company of people experiencing psychosis were also discussed, which described a more physical-emotional experience within the therapeutic relationship. Somatic transference and countertransference have been described as encompassing the bodily felt sense of the HCP, arising from intersubjective somatisation and identification within the therapeutic relationship (Forester, 2007; Athanasiadou and Halewood, 2011). This interpretive repertoire captured how participants made human-to-human connections with the person.

4.2.3.1. Being Trauma-Focused. In terms of aetiology, HCPs made sense of the person experiencing psychosis in terms of two discourse resources, a biological-focused discourse and a trauma-focused discourse. These discourses created certain subject positions and shaped therapeutic relationships. The biological discourse focused upon the viewpoint that psychosis involves impeded structure and function of the brain. Medication was framed as the primary method of moving from illness to wellness. Medication compliance was a prevalent term and positioned in opposition to a relational way of working. The trauma-focused discourse was construed as a broader, systemic view

of the person that emphasised the experience of trauma as the cause of dysfunction. Within this discourse, there was more emphasis on talking, listening, validation, empathy, and providing time to process trauma. The trauma-focused discourse not only acknowledged historical trauma, but also the current trauma of being in hospital, and was seen to enabled more validating therapeutic relationships to form.

Cathy answered the question; what hinders the therapeutic relationship in AMHS? She stated the *"emphasis on >medication compliance<"* within *"the team as a whole"* as hindrance to the therapeutic relationship.

Extract Fourteen.

the team as a whole (2) inadvertently↑ perhaps↑ sometimes inadvertently↑ place a lot of emphasis on >medication compliance < [...] at the place where I'm working at the moment (.) there's a lot of (.) >and probably nationwide to be fair< a lot of emphasis on medication compliance we weren't discharging unless we can be <u>sure</u> that you're taking a medication and the person feels very [...]quite aggrieved by that and it's a very <u>significant</u> medical model (.) the narrative is very significantly linked to that (Cathy, line 632-642)

The use of the words; *"place a lot of emphasis"* is a discourse process that highlights predominance of the biomedical discourse resource of *"medication compliance"*, which she posits is a *"nationwide"* rhetoric. Cathy perceives this condition for discharge as a hindering factor to the therapeutic relationship. The pauses, speeding up and slowing down of the speech, and the questioning pitch of *"inadvertently"* twice, are all discourse processes that indicate tentativeness and conflict about positioning her workplace and staffing team as contributing to the hindrance of the therapeutic relationship by adhering to the *"medical model [...] narrative"*.

Cathy notes that medication compliance as a condition of discharge *"aggrieve[s]"* the person but tones down the aggrievance from *"very"* to *"quite"*. This denotes further tentativeness in engaging in a subject position in opposition to the *"team as a whole"*, presenting an ideological dilemma of working within an environment that holds a *"medical model [...] narrative"*, whilst also

attempting to be *"alongside the person"* (Cathy, Extract Three). Within the discourse process, Cathy appears to balance out the predominance of a biological-focused care.

Valerie reflects on the biomedical focus of her nurse training and refers to a forensic AMHS where she was on placement.

Extract Fifteen.

when I was in a forensic placement [...] you really are just trying to keep a very chill environment in there you don't want anybody kicking off or feeling bad so the medication [...] they didn't have to negotiate for it [...] because medication is just a Band-Aid (Valerie, line 638-662)

She highlights the importance of keeping *"a very chill environment"* in this forensic unit and there appears to be an assumption that medication would be the route to achieve this, which positions medication as a sedative to prevent people from *"kicking off"* or *"feeling bad"*. She acknowledged that *"medication is just a Band-Aid"*, which is defined as a temporary solution that does not address the cause of the problem (Cambridge University Press, 2020). This hints at an ideological dilemma between *"Band-Aid*[ing]*"* the problem to keep things calm for the ward, staff and patients with medication and an awareness of its insufficiency as a healing tool.

Valerie states *"that nurses need more trauma training"*, which is positioned as a means to help understand the impact trauma has on MH concerns, and discusses both medical and trauma discourse resources within AMHS being present but not in a joined-up way.

Extract Sixteen.

I think that nurses need more trauma training [...] I'm not going to say in-between (.) certainly not psychology and the team but psychiatry and the team because obviously they're coming from two different models [...] I think their model is let's chemically alter this person's body[...] but I understand that that's the medicine that they're coming from [...] you're unwell because you are chemically imbalanced in some way and they seem to pay tacit to [...] "oh yes because this horrible child sexual abuse happened and then they became homeless and so they have suffered you know lots of health inequalities" but what they really need is this amount of medication and it will make

it all better [...] whereas I think if nurses had (.) because when we <u>have</u> that therapeutic relationship when we <u>do</u> have a trusting relationship with someone and they give us (2) information about things that happen to them in their lives (.) that knowing how to respond to it (.) knowing how to help them feel safe after disclosure (Valerie, line 882-902)

Valerie talks about three roles within AMHS: the nursing *"team"*, *"psychology"* and *"psychiatry"*. The psychiatry model is understood to *"chemically alter this person's body [...] because you are chemically imbalanced in some way"*. She also states that psychiatry *"pay tacit"* to trauma that the person may have experienced, offering a critique of this position. Her statement; *"whereas I think if nurses had (.) because when we <u>have</u> that therapeutic relationship..."* clarifies her action as constructing a subject position opposed to psychiatry that might consider that *"what* [the patients] *really need is this amount of medication and it will make it all better"*. Therefore, Valerie makes sense of the therapeutic relationship as requiring more focus on traumatic events and being able to respond appropriately and create safety within the therapeutic relationship in the disclosure of trauma.

4.2.3.2. Making a Connection with the Person Experiencing Psychosis - Transference and Countertransference Experiences. As an introduction to this interpretive repertoire, I shall present an extract of co-constructed talk between Diane and myself

Extract Seventeen.

I think when you're genuine they can pick up on it even if their psychosis is present (.) yeah in my experience anyway [Researcher: so when you explain that to me you're saying it with your- with your hands here as if it's a body to body communication] yeah [Researcher: and that's how you (.) it's a felt sense] yes [Researcher: it that right?] it is definitely a felt sense [...] yeah I know when someone is connecting with me even when there's psychosis present I know there's a connection there [...] so that makes it a therapeutic relationship (Diane, line 16-29)

Diane attributes genuineness as a quality in the therapeutic relationship that can be detected, *"even if their psychosis is present"*. I attempt to make sense of this in the interview with a co-construction of this discourse by pointing out her gestures of moving her hands and arms between

us; *"so when you explain that to me you're saying it with your- with your hands here as if it's a body to body communication"*, to which she confirms that I have made sense of her expressions in the way that she intended. This co-construction of the meaning of *"felt sense"* confirms that she intends for this to be understood as a somatic experience. This would be difficult to measure with quantitative methods but exploring this as a speech action it can be interpreted as making a connection with the person that is shared somatically.

Freya discusses countertransference experiences in building therapeutic relationships, specifically with *"older men who had negative symptoms"*.

Extract Eighteen.

> *those with negative symptoms↑ [...] especially older men who had negative symptoms of schizophrenia or psychosis (.) were very difficult because they were completely uninterested (2) in forming a relationship or you know this kind of (.) complete aversion so I had to be very forceful- not forceful kind of badger-y and I felt kind of nagg-y [...] and this wasn't something I was comfortable with (Freya, line 216-222)*

The difficulty in the *"completely uninterested"* and *"complete aversion"* could be transferential in nature. The use of the words complete(ly) is an absolute term that construct a sense of stuck-ness. This provokes some behavioural countertransference of becoming *"badger-y"* and *"nagg-y"*, as Freya feeling a need to force the connection with the person experiencing negative symptoms of psychosis. This creates an ideological dilemma for Freya as she also appears to step into a subject position of the willing and attentive helper, but without the willingness of the patient she might have felt that her subject position was more of a imposed helper, which *"wasn't something* [she] *was comfortable with"*.

Cathy also described encounters as *"stimulating"* (Appendix J, Cathy line 388 – 396) and Freya noted a sense of feeling *"spacey"* and *"scary"* (Appendix J, Freya line 252 – 253), which could be conceptualised as a somatic countertransference (Forester, 2007; Athanasiadou and Halewood, 2011). Feeling *"incriminated"* (Appendix J, Freya line 160 - 255) could be described as

another defence mechanism called projective identification (Melanie Klein Trust, 2020), with the HCP feeling persecuted when working the people who were experiencing symptoms of paranoia.

Valerie also appears to share the subject position of the willing and attentive helper and was transparent about her *"egoistic"* gains from being *"altruistic"*. Feeling good for helping people in distress could be seen as a countertransference associated with an excessive self-sacrifice countertransference schema (Leahy, 2001).

Extract Nineteen.

I don't like seeing people in distress (2) and it's a very very very rewarding feeling to be there for someone when they're in distress for me my training was completely (.) absolutely 50-50 altruistic egoistic I am very much compelled to help people and it makes me feel good to do it [...] if you make dinner and it was amazing you're like "ahhh" (.) but I'm not the right person for everybody so I don't think I can nurse everybody to the same degree I don't think I can you know not everybody is going to enjoy my style of nursing (Valerie, line 774-782)

The *"very very very rewarding feeling"* offers intrinsic dividend that Valerie receives for ascribing to the willing and attentive helper subject position, which could immunize her from potential disappointed or disheartened countertransference because she is fully aware of her drives and intentions in helping and that she gains something intrinsically out of helping and therefore satisfaction from her job. She follows this with; *"I don't think I can nurse everybody"*, which is a discourse process that relays a sense of integrity to her own *"style"* of nursing. This was interpreted as an expression of a strength of character and a healthy understanding of one's limitations to please everyone, which would prevent a demanding standards countertransference schema (Leahy, 2001).

4.2.4. The Therapeutic Relationship is not Just Between Two People – The MDT

This interpretive repertoire highlighted the varying discourse resources about care, management and treatment of inpatients experiencing psychosis throughout the members of the MDT. Participants used discourse processes that resembled splitting within the team, in terms of object relations theory (Klein, 1996), with some members being positioned as relatively good and others as bad. At other times, discourse processes were used to create a sense of team integration

and a willing utilisation of the available professional diversity. These team dynamics influenced how HCPs made sense of the therapeutic relationships with the person experiencing psychosis in AMHS.

4.2.4.1. Professional Differences Create Splitting Within the Team. Different members of staff have different ideas on care, management and treatment and this is talked about implicitly and explicitly as splitting, which brought about a *"them and us"* (Extract Twenty-One) rhetoric. Klein (1996) describes splitting as perceiving others as either good or bad. Within cognitive theory, this would be conceptualised as dichotomous thinking (Kennerley, Kirk and Westbrook, 2016). In Extract Twenty, Diane's narrative illustrated her talk of splitting.

Extract Twenty.

[Researcher: you must be quite popular on the ward] well yeah popular or unpopular depending on the dynamics of- the splitting coz if someone had been assaulted it happened two weeks ago a lady threw the ward phone at a staff member and it hit them on the head so then everyone else is rushing for the restraint and they've got her in holds and she's fighting and then I've come along and said "come on let's go to your room" with the rest of the team walking behind because otherwise she's fighting and someone else is gonna get hurt basically I think it's good if you can have that kind of relationship to step in but I don't know if everyone appreciates that but it works out best for everybody it's more therapeutic that she doesn't get dragged to her room by two men and fighting them all the way and kicking them and everything else which was what was happening and someone she trusts can come and say "right, lets walk instead" (Diane, line 396-419)

Diane interprets that other members of the nursing team may not appreciate her stepping in, as she is expressing a difference in managing this incident to the rest of the team. The subject positioning of *"everyone else rushing for the restraint"* is a discourse process that argues against the use of *"restraints"* and *"holds"* as they may cause more distress and injury. Therefore, different opinions of the management of aggressive behaviours is an example that can cause splitting within the team. This could positively impact the therapeutic relationship with the HCP who aligns with the patient but could also negatively impact HCP-HCP relationships.

Sarah highlights the *"inconsistencies in the team"* and notes that this negatively impacts the *"delivery of a high standard of care"*.

Extract Twenty-One.

I think you have to be a strong team and there's a high turnover of staff so I think (.) when you don't have a strong team there's inconsistencies in the team that makes it difficult to deliver (.) a high standard of care because from one shift to another you'll be doing different things and I think that's really difficult not only for staff but for the young people (.) they don't know where they're at necessarily (Sarah, line 66-70)

This extract has less of a *"splitting"* rhetoric regarding different staff, in comparison to Extract Twenty but does highlight the high turnover of staff being the cause of the inconsistencies, which was reflected across the data. The use of the word *"team"* holds some connotations of solidarity, and the inconsistences appear to be a threat to this sense of solidarity. Therefore, it could be concluded that the high turnover of staff could be considered a hindrance to building therapeutic relationships with people experiencing psychosis in AMHS.

Cathy constructs a subject position for ward staff as gatekeepers to psychology with their narrative about the treatment of psychosis following psychopharmacological protocols rather than considering them for psychological therapy.

Extract Twenty-Two.

those who have been diagnosed with a:: some kind of psychotic disorder↓ [...] I find that the staff team tends <to then go> predominantly (.) >medication< (.) when that happens (.) it's like it's a very very special case (.) if they consider that a referral to psychology could be helpful and we don't often get referral like that >which is something we are trying to work on< (.) we're trying to emphasise that we work with people anybody so to speak who experience emotional distress including↑ those who are diagnosed with some form of >you know who you think have a psychotic disorder< they can also be emotionally distressed so I think that's definitely one parameter that I wonder if it effects whether or not the therapeutic relationship could be shaped

or affected by how people see referrals to psychology depending on the person's diagnosis or what the diagnosis is (Cathy, line 382-396)

Cathy positions ward staff as gatekeepers to psychology and it is a *"very very special case"* if they refer a person with a diagnosis of psychosis to the psychology team. This splits the MDT and constructs a rhetoric of imposed limitation on the ability for the whole MDT to offer an integrative approach to patient care. Her discourse processes draw from unified protocol discourse resources that emphasise emotional distress as a common factor of all MH diagnostic categories (Barlow et al., 2004). In stating; "*we're trying to emphasise that we work with people anybody [...] who experience emotional distress including↑ those who are diagnosed with [...] a psychotic disorder"*, Cathy positions the psychology team as educators to the ward staff to encourage a holistic approach and to include psychological services within the MDT for people with psychosis. This implies that the therapeutic relationship is more than a patient-HCP dyad and can be instead shaped or restricted by ward staff.

4.2.4.2. Professional Diversity Creates Broader Understandings. The MDT model of working within MH care enables the team to draw from many different perspectives. A team of varying perspectives needs to integrate their differing epistemologies and methods of working, and evidence of integrative working was also found within the data. Participants' talk demonstrated a construct of working as a team by; acknowledging the weaknesses and embracing the strengths of each professional body represented within the team and supporting each other through shared knowledge and application in practice.

Lana expresses the difference between the doctor's role and her role as a nurse and how she can advocate for the patient in order to fill a gap between patient and doctor.

Extract Twenty-Three.

it is very different I suppose to the doctor the doctor comes to the ward sort of two or three times a week sees these patients and that's it and he goes [...] and then they will always feel that the doctors are an authority figure because they make decisions regarding leave and sections and things like that so I suppose our therapeutic relationship allows us to bridge the gap between the patient to doctor [...] we feel that we can be a really good representative sort of advocate (.) and I

have many a patient that don't like the doctor because they feel that they don't listen because they don't use the right words or the right terms [...] So well that's okay let's sit down beforehand what are your goals what do you need from this ward review and if you can't find the words I will find the words for you during that time and I think that helps that they feel that (.) it's sort of essentially someone on their side [...] you need to build your allies [...] so I suppose that's how maybe our patients perceive us nurses (Lana, line 79-102)

Lana points out that the doctor spends less time with the patient than nurses do, and the doctor is positioned as an *"authority figure"* who has the capacity to section someone or prescribe leave. The nurse *"bridge*[s] *the gap between the patient and the doctor"* by assisting them in *"finding the words"* so that their voice is heard by the doctor, who is positioned here as being unable to hear the patient's words unless they are the *"right words or the right terms"*. The patient's words are considered incorrect in relation to the doctor's language, which indicates the way Lana makes sense of the patient's use of language as perhaps insufficiently medical or technical. Lana positions the nurse as an *"advocate"* for the patient, *"someone* [who is] *on their side"*, and constructs the patient as having to *"build [...] allies"* with the nurse. Therefore, the therapeutic relationship is more than just between the nurse and patient, it also incorporates *"a doctor's therapeutic relationship with a patient* [which] *is quite superficial"* (Lana, line 1261-1262), and the nurse compensates for this by being a bridge between doctor and patient.

Valerie discussed seeking advice from the psychologist and trades information about what has been happening on the wards for some advice on *"what kind of support"* she can offer.

Extract Twenty-Four.

if a psychologist hasn't been on our ward in a week and a half a lot can happen in a week and a half and I suppose that if you like I'm trading with the psychologist about what I've discussed with the patient it's in the notes [...] so I can say you know "I just want to catch you for a minute because I had this really interesting discussion with room 2 [...] I just wanted your advice what kind of support can I offer them [...] I'm information sharing as I should be (.) but I'm asking for their professional opinion which gives them a sense that I respect where they're coming from and I would like their advice [...] so my job is not just to build a relationship with the patient it's to build

it with the rest of the staff because if I don't have a relationship with them how am I going to be able to have a therapeutic relationship maybe I suppose maybe actually to look at it it's actually a chain it's not just between two people it could be between three four or five people (Valerie, line 1045- 1072)

This narrative of sharing ward information to learn more about the psychologist perspectives of the patients, is how the therapeutic relationship can be seen as more than just a dyad. Valerie constructs the therapeutic relationship as a *"chain"* of *"three four or five people"* from the team, which provides a coherence within the team. Her construct of the therapeutic relationship as being reliant on the MDT reflects the interpretive repertoire about team working to create holistic care. Additionally, she views the therapeutic relationship as more than just between two people, that it consists of a chain that links all members who all have a valuable input.

This notion reflects the ethos of the integrated MDT that is not split or conflicted and is summarised by Lana towards the end of the interview.

Extract Twenty-Five.

I mean the MDT are absolutely brilliant they help so many patients in so many ways that I think if we were one profession alone we wouldn't capture the patient's needs and be able to work to meet those needs (Lana, line 1223-1225)

This interpretive repertoire reflects how participants made sense of how the MDT can work to create joined-up integrated care for the patients, and there is also an acknowledgement that this does not always occur and that there are clashes between differing members of the MDT. However, it appears that it is inescapable that the MDT structure within AMHS impact on the therapeutic relationships that are created within it, that they are more than a dyad. Therapeutic relationships could be seen with a sense of complexity between the MH system and the patient that perhaps resembles familial dynamics. Perhaps there are benefits that could be yielded from the contrasting and complimentary nature of the MDT that can help the patient in varied ways.

Chapter Five: Discussion

5.1. Introduction

This research identified four interpretive repertoires from six semi-structured interviews investigating how HCPs make sense of the therapeutic relationship with people experiencing psychosis within an AMHS setting. As explained in Chapter Four, the interpretive repertoires (Table 2, left column) described how participants made sense of the construct of what the therapeutic relationship is and does, and discourses (Table 2, right column) describe more action-orientated, process inclined talk detailing how participants made sense of how they achieved therapeutic relationships with people experiencing psychosis in AMHS.

Chapter Two evaluated the previous literature regarding how the therapeutic relationship is understood from; the perspectives of various theoretical frameworks, the historical and cultural context of the AMHS, and in terms of how diagnosis can impact the therapeutic relationship. Evidence has also established the therapeutic relationship as important and associated with positive outcomes, especially when working with people with complex and enduring presentations, such as psychosis (Stiles, 2012; Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Horvath et al., 2011; Friedlander et al., 2011; Shattock et al, 2017). However, there was limited understanding of how HCPs manage therapeutic engagement with patients in AMHS or how the discursive environment impacts this therapeutic process. Due to the methodology of this research, which adopts a social constructionist perspective and focuses upon the analysis of discourse resources (macro-level) and processes (micro-level) available to HCPs, some light has been shed on how HCPs construct their subject positions and make sense of their therapeutic relationships with people experiencing psychosis within an AMHS. Therefore, this research contributes to filling the research gap in the literature, and this chapter will demonstrate how this has been achieved. Limitations of this research, implications for clinical practice and future avenues for research will also be suggested. Finally, the third part of my reflexivity regarding this research project will be presented giving an overview of the entire process of conducting and writing up this research thesis, as well as what I have learned, and how this research has developed me as a trainee counselling psychologist and researcher.

5.2. Differences in the Talk Between Nurses, Psychologists, Trainees and Qualified

There were overarching similarities in which all HCPs, whether nurses or psychologists; qualified or trainees, talked about how they made sense of the therapeutic relationship with people experiencing psychosis in AMHS, and these were captured in the interpretive repertoires and discourses. However, there were also nuanced differences between the way the various HCPs used discourse resources and processes whilst talking about this topic. This section aims to draw out those differences, not for the purpose of conducting a comparative study, but to note the differences within the discourses and to reflexively evaluate the factors that may have contributed to these differences. Within the interviews I was aware of how my status as a Trainee Counselling Psychologist could have been a factor in the dynamics between myself and the interviewees. There appeared to be a greater affinity between myself and the Counselling Psychologists, particularly the trainees. There was an apparent shared language and non-verbal affirmations that increased the sense of understanding within the interview data. Additionally, the content of their talk featured the therapeutic process within talking therapy. This made for a "chattier" process that I noticed took me away from the interview schedule, arguably making for a longer and more arduous interview and analytic process. Contrastingly, the dynamics between the nurses and myself were more educational, learning about what the therapeutic relationship meant for them. There appeared to be less shared affinity, understandably, and there was a sense of difference, perhaps due to our professional differences. However, this did not appear to inhibit the interview flow, but could have constrained what was discussed openly. The content of the interviews featured more talk about everyday ward duties and activities and how these contribute to building therapeutic relationships. Considering this reflexively, the difference of professional roles within the MH system may have impacted the content that was shared, and the data gathered. Potentially, this could have been managed by having a nurse researcher conduct the nurse interviews, to have had two focus groups; one with nurses and one with psychologists, or to have a more neutral interviewer conduct the interviews.

5.3. The Therapeutic Relationship Bridges the Mental Health System and the Person Experiencing Psychosis

This interpretive repertoire highlighted the two discourse resources; biomedical and humanistic and highlights the corresponding ideologies that are embedded within the MH care system and are often also evident in people's expectations of MH services. Previous literature has identified a historical basis for these discourses about MH and AMHS; biomedical assumptions, such as deviance (Milton et al., 2010), confinement (Foucault, 2001) and the illness-wellness dichotomy (Engel, 1977); as well as humanistic and anti-psychiatric movements illustrated by Quakersintherworld, (2018), Laing (1960/2010) and Kesey (1962). Additionally, Cahill et al. (2013) identified two camps in MH nursing, the therapeutic relationship and the biomedical.

The current research data featured both of these discourses and confirmed that they appear to permeate assumptions about the MH system, HCPs, and people accessing MH services. Additionally, current policies and guidelines, such as "valuing relationships: The value of relationships between people is of primary importance" (CCQI, 2017, p.3), and therapeutic literature emphasising the importance of the therapeutic relationship as a secure base in therapy (Bowlby, 1988) were evident in the data in how participants discussed their role and interactions with patients, adding concrete illustrative narratives of how this is important and why, which has added pragmatism to the previous theory and research. This interpretive repertoire suggests that the therapeutic relationship is negotiated within HCPs discourse processes in how they balance the dialectical qualities of biomedical and humanistic discourses. This was implemented through the amalgamation of two subject positions, one of which aligned with the MH care system and the other with the patient's experiences. For example, participants discussed working within a predominantly biomedical setting that possessed institutional authoritative properties, *"we have taken their liberties away"* (Extract One). Additionally, HCP-patient relationships were constructed as predominantly directive and system-centred *"another professional talking [...] at them"* (Extract Three), which could attribute to people becoming *"disenchanted with it* [the MH system]*"* (Extract Two). This highlighted that participants seemed aware that, from the patient's view, they represented an authoritative system. However, they also positioned themselves in opposition to this; *"being alongside the person"* (Extract Three) and *"I'm friendly but I'm not your friend"* (Extract Two). This

oppositional subject position supports Larsson et al. (2012) who identified a contrarian subject position constructed by counselling psychologist that opposed biomedical interventions, such as medication, whilst working with people with the diagnosis of schizophrenia. However, due to the identification of a dual subject position, this interpretive repertoire expresses a dialectic subject position *within* the MH system and simultaneously being *alongside* the person.

The dual subject position highlighted an ideological dilemma that participants expressed that helped them to make sense of and integrating the incongruence of being both representatives of the AMHS and also being aligned with the person's experiences. This is illustrated in Extract Five *"but I also do think my job is to offer medication to someone who is in distress you want to talk to them offer your ears first"*. In this quote, Valerie makes sense of her role as medicator and listener and also appears to position herself away from the biomedical discourse with the contrarian subject position. Putting this together as a dual subject position manages the patient expectations of her role by both identifying herself within the biomedical aspects of her role as medicator and challenges the assumptions that her role is purely biomedical. This appears to enable HCPs to hold a dialectical position in order to bridge the MH system and the person experiencing psychosis. This ability to hold two opposing positions is supported by psychological theories such as the ICS model of the mind (Teasdale and Barnard, 1993) and DBT states of mind diagram (Linehan, 1993) that illustrate how the mind enables a balance between implicational/emotional and propositional/reasonable ways of knowing the world. It also relates to the concept of the therapeutic relationship within CBT, which Gilbert and Leahy (2007) consider as an "important vehicle" (p.132) that delivers the interventions to the patient, and Delaney et al. (2017) notion of the "empathic bridge" (p.636).

5.2.1. Building Trust by Aligning with the Person's Experiences

Rogers (1967/1986) named unconditional positive regard, empathy, genuineness, and authenticity as qualities of the person-centred therapist. Although these words did not emerge from the data, many were expressed indirectly in the interviews. Building trust by aligning with the person's experiences was one of the main discourses across the data, which expressed how participants empathised with the anxiety and distress being in AMHS could pose for the person experiencing psychosis, and how building a sense of trustworthiness could bridge the MH system

with the person experiencing psychosis. The dual subject position of being part of the MH system and being alongside the person was used to build trust by gaining a sense of diluteness from their MH system subject position and emphasising their allegiances to the patient's own needs. This supports previous literature that captured service-users' experiences and emphasised the importance of being heard, empathy and mutual respect, which helped build trusting patient-HCP relationships within AMHS (Walsh & Boyle, 2009).

Previous research has also found that trustworthiness is a quality that is important for HCPs to possess when working with people experiencing psychosis (Shattock et al., 2017). However, developing a trusting relationship has been found challenging with people with cluster A personality presentations (Lingiardi et al., 2005). Priebe and McCabe (2006) suggest that being calm, helpful and sensitive to the patient's needs foster good therapeutic relationships. This was also evidenced within the current research as participants expressed their acceptance of the patients testing their trustworthiness and also demonstrated a clear understanding that trust is fundamentally important for building a therapeutic relationship with people experiencing psychosis. However, the data also highlighted that trust can take a long time to build, which appears to be an issue within AMHS where stays in hospital can be relatively short. Nevertheless, holding awareness to these time restrictions was also expressed by participants through an emphasis of the importance on the person over these limitations.

5.2.2. Managing Expectations

Discourses that position the patient as sceptical and *"disenchanted"* (Extract Two) with the MH system were expressed and appeared to construct expectations that HCPs are not able to help and are not trustworthy. Furthermore, expectations around the illness-wellness dichotomy were also constructed in terms of what patients were perceived to expect from the MH system; *"you've come in because something's wrong and here's something to fix you"* (Extract Four). It is suggested that these expectations could be considered discourse resources that are made sense of and adapted using discourse processes in several ways to accept and deny certain avenues of care. These discourse resources position the HCP as the healing or solution source, and consequently positions the patient as passive in the process of recovery, arguably reducing their self-efficacy, expecting to be fixed by

the HCP or the MH system, which is positioned as holding power. In Extract Four, Cathy highlights this issue and describes how she might shape the person's subject position by holding this expectation by *"being alongside the person"* regarding what they want (to get out of hospital) whilst simultaneously informing and challenging it and showing them a *"complementary approach to treatment"*. This is an example of the way HCPs makes sense of the discourse resources about AMHS and the MH system being focused on medical treatment protocols. They used discourse processes to express an opening up of the patient's idea of recovery in a way that might increase their self-efficacy with a new and alternative way to them taking charge of their treatment as opposed to sticking with a one-dimensional medical protocol. These findings support theories of MH care and current policies and guidelines that support holistic care (Cowdrill & Delhaney, 2009; NICE, 2014; CCQI, 2017) and conform with third-wave CBT interventions that focus on emotional experiencing and acceptance of emotions (Linehan, 1993; Clarke & Nicholls, 2018). Additionally, Chadwick (2006) advocates for a radically collaborative approach in building therapeutic relationships with people experiencing psychosis. The managing expectations discourse highlights the importance of being aware of assumptions and expectations so that a radically collaborative approach can be achieved.

Additionally, participants discussed medication in terms of being *"a chemical quash"* (Extract Five) and the expectation that nurses can be perceived as merely *"a Pez machine for Diazepam"*, which is acknowledged but challenged in their talk. Hence, their sense-making of the therapeutic relationship was one that occupies the dual subject position, being part of the MH system that adheres chemical suppression of feelings and emotions, and being alongside the person's emotional experiences, aiding an acceptance of feeling and expressing emotions. This contradicts Cahill et al. (2013) who state that nurses are in one camp or another. Within this interpretive repertoire nurses and psychologists attempted to be in both at the same time, which appeared more challenging for nurses given their more hands-on role.

5.3. The Therapeutic Relationship as a Means to Manage Psychotic Experiences with a Boundaried, Consistent, yet Flexible Approach

This second interpretive repertoire highlights other contradictory and dialectical discourse resources that were synthesised by HCP to manage unpredictability. Unpredictability was a common discourse that was used to describe the qualities of psychosis. The boundaried and consistent approach was consistently talked about as a way to offer a secure and predictable environment. Ward rules were an example of this that was positioned as an authority above HCPs that all had to adhere to. The flexible and creative approach involved a bending of the rules and out-of-the-box, creative thinking that was used to manage cognitions and behaviours that were unshared with others and could be described as possessing a paranoid or delusional nature.

Previous literature highlights that flexibility and sensitivity to patients' needs is a quality of the IPR approach to therapeutic nursing (Peplau, 1991) and that nurses hone their skills, such as using therapeutic boundaries, listening, developing a non-judgemental attitude, as well as a good use of humour and empathy, experientially and intuitively (Scanlon, 2006). Similarly, this interpretive repertoire featured parable-type narratives from ward life, which uncovered how these contradictory discourses were negotiated and made sense of experientially. This gave a flexible and sensitive human-to-human quality to HCPs working in AMHS with people experiencing psychosis. Rogers (1967/1986) positioned himself in opposition to the movement towards professionalization, which could objectify the person as merely a diagnosis and create distance between HCPs and the person experiencing psychosis. It was posited that the rules as well as the bending of them are equally important to the HCP-patient relationship. The rules create the secure base and consistency that may relieve anxiety related to the unpredictability that the person is already experiencing, and the bending of the rules adds the personalisation and shows adaptability to the already confined and restricted patient. The quality of a dialectic being neither good nor bad, right or wrong, both are required for the care of the person experiencing psychosis. Linehan (1993) discusses the principle of continuous change embedded within DBT, which states that the nature of reality is full of opposing forces that require synthesis with no fixity within the process of change, to hone and ever refining a sense of balance and harmony (Linehan, 1993). The data from this research reflects this nature of reality within the concepts of the therapeutic relationship with people experiencing psychosis.

5.3.1. Being Consistent and Boundaried

The therapeutic discourse *"holding environment"* was used to describe the AMHS, which supports Winnicott's object relations theory of the *"nursing triad"* (Casement, 1985/1997, p.12). Casement (1985/1997) describes a triangle regarding the supervisor-therapist-client triad, the supervisor holds the therapist, whilst the therapist holds the client, similarly to the father holding the mother, who holds the baby. This also relates to the fourth interpretive repertoire, which expands on this by encompassing many members of the MDT. Although there is some overlap, this is considered in a different light, as within this second interpretive repertoire this holding environment offers a sense of being containing and boundaried. This interpretive repertoire addresses how a creative approach to building therapeutic relationships is borne from a sense of structure and holding by more senior members of the team.

Being a consistent presence was also viewed as useful in building therapeutic relationships from the first interactions with people in a PICU. Seeing people at their most *"raw"* (Extract Ten) and distressed was constructed as a factor that built a therapeutic relationship, as the same members of staff saw them when their psychosis is most disorientating and distressing. Diane also discussed how *"it helps if you're not scared"* (Appendix J, Diane, line 170) by patients' actions that could be described as aggressive, and how patients are scared enough without the fear of staff adding to that. This grasps the essence of the discourse of being consistent and boundaried, by taking a containing, normalising and non-judgemental stance. These findings support previous literature that identified aggression as a barrier to building therapeutic relationships (Wood & Pistrang, 2003; Moreno-Poyato et al., 2016; Nijman et al., 2015), and compliments social learning theory that states that aggressive behaviour is determined by observational, structural and reinforcement factors (Bandura, 1978). A non-judgemental, person-centred approach (Rogers, 1967/1987) was expressed within this interpretive repertoire and appeared to diffuse aggressiveness. Compassion-Focused Therapy (CFT), has been successfully introduced in AMHS with people experiencing psychosis (Heriot-Maitland et al., 2014). Anger and aggression are understood within this third-wave CBT approach as a protective response to perceived threats (Gilbert, 2009).

5.3.2. Being Flexible and Creative

The other aspect of this dialectical interpretive repertoire was expressed through discourses that advocate being flexible and creative. Participants described the holding environment of AMHS as a means to enable some flexibility to when and for how long patients were seen by psychologist and nurses *"one-to-one time"* (Extract Eleven) and did not always involve a sit-down meeting, instead requiring the HCP to adapt their approach to meet the person where they were and gain *"those little snippets"* (Extract Eleven) that help to formulate a plan. This concurs with the flexible and responsive approach outlined by Peplau (1991) with regards to nursing and expresses sensitivity and empathy towards the person's tolerance for therapeutic input, which could pay off in the long run.

Extract Twelve outlines a narrative about managing delusional thinking by validating the emotional state of the person and not challenging the delusion outright. This highlights how this flexible approach is put into practice and is also related to the bridging of a biomedical and humanistic approach from the first interpretive repertoire. This is an example of the validation of experience, active listening and accurate empathy that Freemantle and Clarke (2009) advocate in order to build rapport with people experiencing psychosis.

Another narrative of ward life described how a nursing team made a deal to achieve medication compliance by becoming compliant to the patient's request for them to recite an Islamic prayer (Extract Thirteen). The wider system was described as lacking in *"creative thinking"* and it was implied that it was up to the individual HCP to apply this creative approach to gain medication adherence and work within the person's tolerance for therapeutic input. This creative approach could be described within therapeutic literature as use of self, which involves "the operationalisation of personal characteristics so that they impact on the client in such a way as to become potentially significant determinants of the therapeutic process" (Wosket, 2002, p.11), although discernment to the extent that this is taken would also need consideration. Wosket (2002) also suggests that taking an individualistic therapeutic approach is in opposition to some forms of therapeutic professionalisation, which endorse the use of techniques but condone the use of self. Therefore, this interpretive repertoire, with the dialectical approach of being both consistent and boundaried as well as flexible and creative, presents an ideological dilemma between the professional and personable

subject positions. It has identified how HCPs construct these different positions of being responsive to the system and the person, and how they position themselves along the continuum of a dimension of being professional-personable.

5.4. Meeting the Person Experiencing Psychosis Through the Therapeutic Relationship

This interpretive repertoire reflected two discourses associated with the aetiology of psychosis and MH issues generally, that MH diagnoses have biological origins, and originates from trauma in the person's history or current life. A biological discourse might denote that the person's brain has a physiological and anatomical abnormality that creates dysfunction in the mental state of the individual; this can be a predisposition or acquired. Alternatively, a trauma discourse posits that the individual has adapted and developed emotional, cognitive and/or behavioural ways of coping with situations that were threatening (e.g.; abuse, trauma, and loss) to themselves or their social status, and would also position what we call MH diagnoses is a natural and normal response to adversity of some kind. The biological discourse appeared to be governed by a medical model of MH that justifies a certain focus on the categorisation and *treatment* of MH diagnoses (McLeod, 2018). And the trauma discourse appeared to be governed by a systemic theory that focuses on environmental factors that have shaped the individual. These discourse resources appeared to have an impact on how participants made sense of the person and how they could relate and empathise with them.

Similarly, more somatic connections were discussed within the data that related to psychodynamic theories of transference and countertransference involving a felt sense of an emotional exchange between the HCP and person experiencing psychosis, which appeared to provide a somatic appreciation of the person's experiences. This stems from Freudian theory that states that firstly the ego is a bodily ego (Freud, 2010), and reiterated in Kleinian theory that details projection, introjection and projective identification (Klein, 1996), which are defences that utilise the intersubjectivity of human connection.

5.4.1. Being Trauma-Focused

The discourses of being trauma-focused arose from the data under the interpretive repertoire of meeting the person through the therapeutic relationship that was expressed by participants' acknowledgement that AMHS culture is governed by a medical model treatment protocol, which

involves taking a medication focus. Participants asserted a desire to step away from medication orientated answers and explore more historical and systemic aetiological factors surrounding the person's admission to AMHS. Nurses discussed how a medication focus featured heavily in their training, but they also expressed a desire to learn more about how, what are described as symptoms of MH diagnoses, can instead be viewed as understandable ways in which the person copes with past and current adversity, abuse, loss or trauma. Additionally, a biological focus was also highlighted with the discourse of medication compliance, which was positioned as an enticement with the promise of discharge, if the patient complied. It was stated that this did not allow the person to make choices regarding their recovery that could involve psychological or relational interventions. This related to the discourse; Managing Expectations, where Cathy stated that the expectations of the individual blind them from exploring a *"complementary approach to treatment"* (Extract Four), and it could be argued that HCPs are also subject to this expectation.

These findings support previous literature that state that time restraints and resource limitations push a biomedical approach to MH problems and lead to the marginalisation of the therapeutic relationship, which would be utilised within relational and psychological interventions (McMullan et al., 2018; Knowles et al., 2015; Höfer et al., 2015; Sweeney et al., 2014; Delaney et al., 2017; Pazargadi et al., 2015). NICE guidelines (2018a) are founded on solution-focused, evidence-based, economic-driven paradigms (Thibeault, et al., 2010; Sobekwa & Arunachalam, 2015) are illustrated by the discourse resources within this interpretive repertoire. However, due to the Payment by Results (PbR) commissioning structure of the NHS, it would appear that this course of action is set, both financially and ethically, as there would be understandable consequences if people were not treated in accordance with the evidence-based treatment protocols. Despite the apparent marginalisation of psychological interventions within AMHS and particularly with people experiencing psychosis, this research found that HCPs negotiate this restraint by adding this desire to be more trauma-focused in their personal encounters with patients, exercising compassion, understanding and empathy, which, at least to a certain extent combats this marginalisation and adds a more holistic approach. However, both being trauma-focused was concluded as necessary to meet the person experiencing psychosis through the therapeutic relationship.

5.4.2. Making a Connection with the Person Experiencing Psychosis - Transference and Countertransference Experiences

Within psychodynamic theory, transference and countertransference can be described as conscious and unconscious processes that originate from self-other mental representations, particularly associated with parental relationships (Lemma, 2003). Additionally, defence mechanisms and resistances can also be apparent within the therapeutic relationship (Lemma, 2003) and somatic countertransference is understood as bodily sensations that are shared between HCP and the patient/client (Forester, 2007; Athanasiadou and Halewood, 2011). This discourse highlighted that participants construct the therapeutic relationship as a space to make these connections with the person experiencing psychosis. Evans (2007) stated that a psychodynamic perspective could offer an alternative to the biomedical conceptualisation of psychosis and advocated for HCPs to understand how to utilise countertransference to aid a more validating and normalising sense-making of their interactions with people experiencing psychosis. Within the current research, there was evidence that a psychodynamic awareness was present and that it can help shape the way HCPs relate to the person experiencing psychosis.

In Extract Seventeen, a felt sense of knowing that there was a connection between patient and HCP was a discourse that was shaped by the discursive process; *"even when the psychosis is present"*, which indicates that there was an assumption that psychotic states might make this connection difficult. This assumption is supported within the literature that suggests that a person experiencing psychosis has social cognitive deficits (Pounds, 2017), which can create therapeutic engagement difficulties (Mitchison et al., 2015). Nevertheless, overall participants discussed making a connection, however subtle, which helped build the therapeutic relationship, and this discourse could suggest that when cognitive deficits are apparent the HCP makes connections through a felt sense or somatic (body-to-body) experience. The way the participants talked about being with a person experiencing psychosis identified rich and varied experiences that HCPs constructed in their talk.

Porges (2011) polyvagal theory (PVT) is a neurological theory that corroborates the transferential experiences that emerged from the research data. PVT explains a phenomenon called

"neuroception" (Dana, 2018, p.4), which is a subconscious, autonomic, biological-behavioural evolutionary adaptation that detects cues of safety and threat received from the body and environment. These cues stimulate various sympathetic and parasympathetic neurological pathways that govern mobilisation (fight and flight) and immobilisation (freeze and dissociation). Dana (2018) also highlighted that these threat responses can be soothed by the engagement of the ventral vagus nerve via the "face-heart" (Dana, 2018, p.31), which controls how we send and receive cues of safety to and from others. Pounds (2017) found that dysfunctions in emotional processing and social perception were prevalent amongst people with a diagnosis of schizophrenia, and PVT offers a biological and neurological explanation to this social cognitive theory and the relational factors that have emerged within this interpretive repertoire.

5.5. The Therapeutic Relationship is not Just Between Two People – The MDT

The therapeutic relationship is commonly understood to be a dyad, however, throughout this data, an interpretive repertoire emerged that positioned the therapeutic relationship as supported and dependent on many members of the MDT. This was talked about in terms of inter-professional and intra-professional differences and diversities; addressing both how HCPs hold different values that can create a lack of cohesion within the team, and also how HCP's differences create holistic-ness and a healthy diversity of the management and care of patients. This dialectical nature of the workings of the MDT could be validated by social identity theory that states that a person's sense of self is bound by their identity to a specific group (Tajfel & Turner, 2004). Within AMHS there are varied professional bodies that hold different values and perspectives, which appeared to be reflected in participants' discourses of the different and often conflictual ethos and management of patient care and ways of working. Simultaneously, participants also held a narrative of belonging, or identifying, as a member of the MDT, which appeared to hold another discourse that reflected working together regardless of professional identity in a complementary way. This dynamic within the team was constructed as impactful to therapeutic relationships in AMHS, and also highlighted an expansive and systemic intersubjective quality of the therapeutic relationship, which also reflects the biopsychosocial model (Engel, 1977) and values of holistic care.

5.5.1. Professional Differences Create Splitting Within the Incohesive Team

Extract Twenty address the diffusion of aggressive or distressing behaviours on the ward and how different members of staff might manage challenging situations. Diane constructs a subject position for herself as the defuser of tension on the ward and assigns the subject position of others as resorting to the use of restraints on the patient. She discusses *"dynamics"* within the nursing team, and from this discourse, we co-construct the idea of *"splitting"*, which indicated that there was a "them and us" construct between patients and staff due to the subject positioning; the idea that Diane was siding with the patient and not the injured member of staff. Siding with the patient or staff member subject positions appears to construct divisions between team members concerning their style of nursing. In their thematic analysis of interviews with nurses and patients, Wood and Pistrang (2004) found a *them and us* attitude between staff and patients that created a sense of vulnerability and disempowerment in patients due to the use of restraints and force. Although the findings of the current research cannot verify this, the dichotomous construct within this discourse is akin to the argument outlined in Cahill et al. (2013) of two camps; the therapeutic relationship camp and the biomedical camp.

Having a high turnover of staff was also identified as adversely affecting the strength, or cohesion of the team (Extract Twenty-One), which supports Pazargardi et al. (2015) who identified that a manpower shortage was an organisational barrier to the therapeutic relationship. Extract Twenty-Two identified rhetoric regarding ward staff's tendency to focus on medication with regards to managing and treating psychosis and were considered gatekeepers to psychology. Their medication focus would often mean that patients with a diagnosis of psychosis were not considered for psychological interventions. This discourse highlighted differing professional roles and values, and although guidelines outlined by NICE (2014; 2018a; 2018b; 2018c) and CCQI (2017) recommend a biopsychosocial approach, it would appear that issues around integration of these perspectives are challenging. This lack of cohesiveness often emerged when participants were asked about the themes from staff room talk and were associated with a reduced quality of the therapeutic relationships between HCPs and patients. This supports Pazagardi et al. (2015) who stated that the therapeutic relationship is overshadowed by biomedical treatments and interventions due to time restraints and perceived quicker outcomes.

5.5.2. Professional Diversity Creates Broader Understandings

An integrative discourse also emerged when participants talked about the MDT. There was a construction of how the different professional roles (e.g.; psychiatrist and nurse) hold different qualities that complement each other. The psychiatrist was positioned as an authority within the team and the nurse was an ally or advocate to the patient, whose therapeutic relationship bridged the gap between the psychiatrist and the patient. Additionally, the nurse communicated with the psychologist, who was positioned as holding a trauma-focused approach, so that they could gain insight into their perspective of the patient. Within this discourse, there was an acknowledgement of differences, but this was discussed as a need to talk with other members of the MDT and work together to find a way to move the patient forward. The therapeutic relationship was identified as more than a dyad between one HCP and the patient, but rather a *"chain [...] between three four or five people"* (Extract Twenty-Four) that supports the therapeutic relationship between any HCP and patient. This was reiterated in Extract Twenty-Five, *"the MDT are absolutely brilliant [...] if we were one profession alone, we wouldn't capture the patient's needs and be able to work to meet those needs"*. The use of the word *"we"* in Extract Twenty-Five denotes the MDT as a group identity. The way this was talked about constructs a sense of belonging and togetherness, which contrasts the previous discourse that created incohesiveness and separateness both intra-professionally and inter-professionally.

The ethos behind the MDT was actively brought into policies with the Department of Health (2002) publication entitled *The Mental Health Policy Implementation Guide*, which outlined a necessity for a multi-disciplinary approach to care in AMHS and is also reiterated in the Standards of Inpatient Mental Health Services that offers guidance in team-working and culture by advising ward managers to promote positive risk-taking and providing "appropriate supervision and MDT support to enable this" (CCQI, 2017, p.19). MDT working has been highlighted as both conflictual, with issues of a desire to protect one's own professional identity and boundaries (Jones, 2006), and collaborative with the "pooling of resources" (Sims et al. 2015, p.21), which support the findings of this research that found both cohesiveness and incohesiveness within the discourses of HCPs.

5.6. Map of Interpretive Repertoires and Discourses

In order to add some conceptualisation and grounding in clinical practice, a model of the interpretive repertoires and discourses have been mapped onto a visual depiction of how they could relate to one another in practice. The following paragraph acts as a narrative to talk the reader through the visual depiction featured in Appendix I.

HCPs make sense of the therapeutic relationship as a ***bridge between the mental health care system and the person experiencing psychosis***. This bridge is built on ***trust*** and ***managing expectations*** - two foundational groundings. The bridge is also built with a fence that provides safe ***boundaries*** on either side to offer safe passage and a ***consistent*** path, and cushioned with a soft, ***flexible and creative*** flooring. ***Meeting the person experiencing psychosis*** from across the bridge, the HCP walks to meet the person on the other side, who explains their history and trauma from their past. The HCP is ***focused on their trauma*** and not on their diagnosis and does not use biomedical language, and makes felt-sense ***connections through understanding the transference and countertransference experiences within the therapeutic relationship***. The ***MDT*** supports the therapeutic relationship bridge by means of pillars that are rightly ***different*** in length and structure as they offer different kinds of support but are connected to each other. This connection is ***created through broader understandings*** between their professional stances and ***splitting is avoided*** by identifying and valuing differences between professionals.

See Appendix I for map of a visual conceptualisation of the interpretive repertoires and discourses.

5.7. Clinical Implications for Practice

This research highlights that HCPs place a great emphasis on developing therapeutic relationships with people experiencing psychosis in AMHS, a clientele and setting that presented many ideological dilemmas and dialectical tensions. These tensions were highlighted in all interpretive repertoires and have many implications for clinical practice. This research has identified that people who have a diagnosis of psychosis are not always considered for psychological interventions due to a predominantly biomedical approach to their treatment and recovery. However, it has been highlighted that ward staff desire a unified protocol and trauma-focused approach that

involves; the validation and normalising of experience, and psychological interventions to aid the patient's management of their emotional distress. This approach could be supported by psychology to help ward staff, who have more contact time with patients, to integrate awareness of trauma-informed work into their practice. Additionally, an awareness of transference and countertransference, associated with positive and negative symptoms of psychosis, were also touched upon in participants' talk. This was another area to explore with ward staff to aid a greater understanding of working with the therapeutic relationship in AMHS and with people experiencing psychosis and could be explored further with qualitative research.

Further implications for practice were raised with the importance of consistency and being present with patients, even when in an acute psychotic state. Consistency within the therapeutic relationship could be understood from object relations theory (Winnicott, 1990) and attachment theory (Bowlby, 1988), which address the importance of providing a secure base and good enough care, whether it be within a nursing or psychological relationship. The final implication for clinical practice that I would like to raise is the importance of the MDT and how the therapeutic relationship with patients was identified as more than a dyad and determined by the team as a whole. The MDT was constructed as a dialectical entity, both cohesive and incohesive, where differences were both utilised and impeded. The MDT is considered supportive to both patients and HCPs. However, the team dynamics were sometimes difficult to navigate when there were disagreements, and as one can imagine this could impact on the sense of consistency within the team and could also impact the patients. Therefore, this research has highlighted the importance of Rogerian qualities of the therapeutic relationship; good communication, unconditional positive regard, empathy, genuineness, and authenticity (Rogers, 1967/1986), within the team as well as with the patient.

5.8. Limitations

The dual epistemological positions of this research, namely, social constructionism and critical realism, has aided exploration of macro-level, top-down discourse resources and micro, bottom-up discourse processes, and it was intended to capture a broader view of the therapeutic relationship within AMHS with people experiencing psychosis, as being both fixed and mutable through talk. These epistemological positions allow for the qualitative exploration into the meaning-making and

construction of reality that was intended to be captured. However, these epistemological positions inevitably do not allow the research to gather generalisable results or give any certainty of absolute truths. However, the validation of qualitative research comes from good use of supervision and reflexivity to become aware of the assumptions and prejudices that might taint the findings. Qualitative methodologies, such as CDP, are designed to gather ideographic data that is rich and unique. Naturally, this limits the generalisability of the data. However, by using CDP over IPA, it was possible to be less bound by sustaining homogeneity within the sample and therefore open up the research to include various members of staff working in AMHS. Indeed, another avenue for future research would be to explore a more varied sample with CDP, including ward managers, psychiatrist, and occupational therapists. The data collection method of semi-structured interviews would have limited this research's ability to gather more naturalistic data. Ideally, CDP method suggests the use of focus groups to gather co-constructed discourses between HCPs to capture the intersubjective nature of the co-construction of meaning within talk. However, this would have proven challenging given the time limitations of this research, however, there could be scope to apply this method of data collection to address this research question in future research.

Within this methodology the researcher is considered a potential participant (Potter & Wetherell, 1987), which creates the co-construction of talk, as discourse is the data being "measured" and is considered a social action and therefore interactional and interpersonal in nature. This creates a subjective experience and interpretation of the topic, however, sacrifices some objectivity. It is therefore important to reflexively consider one's bias and assumptions in order to balance the subjective viewpoint with a critical approach to one's sense making; effectively to analyse the analysist's analysis. This topic was very meaningful and personal to me, as mentioned in session 1.1, Reflexivity Part 1, there was a personal, familial ideology that had filtered my experiences throughout my life, and as such my involvement within this research could also have been a limitation. I carried a number of expectations and assumptions about what I wanted to find in the data, such as an expectation that other HCPs made sense of the therapeutic relationship in similar ways to myself, and the assumption that HCPs held a preference for the idealisation of the non-pathologising approach to MH care. There would have also been a bias in the sampling process, in that this research project would have attracted participants who did, at least to some degree, also

value the therapeutic relationship. There was a sense that my personal and professional values shaped the research questions and interview schedule and could have directed the participants into a certain way of talking about the therapeutic relationship. Throughout interviewing and analysis, I was also aware that my interests and assumptions regarding the research topic affected my behaviour during these stages of the research process. In the interviews, and reflecting-in-action and reflecting-on-action (Orlans & Scoyoc 2008), I felt excited and quite swept away with the direction in which the questions were being answered. This was evident in the recordings and transcripts with my affirmative utterances and interruptions. When this occurred, I felt torn between gathering a more objective frame and staying with the co-construction of the data. Reflecting on this inner conflict, I feel that I erred on the side of allowing my excitement to take over and allow, what could be argued as, too much co-construction of the data. Although, this research did involve co-construction of meaning-making between myself and the participants, and this is accepted as inevitable (Potter & Wetherell, 1987), I had lost valuable objectivity due to not balancing this process more fully. Reflexivity was noted in my reflective diary, discussed with peers and in supervision to help gain more of an observer perspective on this research, and where necessary or appropriate the co-construction has been addressed within the analysis. If I were to conduct this type of research in the future, I would ideally prefer an impartial researcher conduct the interviews and it would also have been helpful to have someone else to analyse the data with me to add validity to the findings.

5.9. Avenues for Future Research

Future research could explore the use of focus groups to gather data using CDP analysis. This could be implemented using social media group chats or private online forums to gather textual data from HCP taking part in a virtual focus group co-construction of meaning in this way. This would reduce the limitation of attempting to organise the logistics of gathering participants to attend a sit-down focus group interview in a physical location.

Other related topics that were touched on in this research, but could warrant further investigation are; how ward staffs use reflective practice, or different professionals within the MDT, to develop their therapeutic practice, and how HCPs experience transference and countertransference, particularly somatically, with people experiencing psychosis, as this was raised

in the third interpretive repertoire; Making a Connection with the Person Experiencing Psychosis - Transference and Countertransference Experiences.

During the process of analysis, it was noted that gathering quantitative data prior to conducting a qualitative study could have added more focus to the interview questions. On reflection, this study could have adopted a mixed method design in order to gather quantitative survey or questionnaire data from a wider sample of HCP. This would have enabled an assessment of general trends and the prevalence of issues that were identified in the current research, which affect the therapeutic relationship between HCP and people experiencing psychosis, such as medication under restraints, patient expectations and the cohesion of the MDT. Further research could explore quantitative data or adopt a mixed method design in order to achieve more generalisable results.

The therapeutic relationship could also be explored within other settings. My recent experience working within IAPT services have enlightened me to how this sector of mental health care is also influenced by the protocol driven, evidence-based practice and the Payment by Results (PbR) commissioning structure, as it is within AMHS. This structure applies financial and performance pressure on this primary mental health care service, adding concern that if therapist do not stick rigidly to the "treatment protocol" they may be applying the "wrong" or "unprescribed" treatment. It is my observation that this pressure can create a dialectical split between "treatment" and the "therapeutic relationship". A working hypothesis could be proposed that being more person-centred within the CBT approach might enhance patient attendance, retention, agency and autonomy, especially with more complex service users who have experienced past trauma or other complexities. Further research could explore how the therapeutic relationship is made sense of within those settings.

5.10. Conclusion

This research has described and defined the importance of the therapeutic relationship within AMHS and used both counselling psychologists and nurses within the sample, as both professions hold a focus upon the therapeutic relationship, although, and with a desire to avoid factionalism within the MH culture, this is not to say that other professions do not focus on the therapeutic relationship. The aims of the research, as outlined in Chapter Two, have been addressed. The main

discourse resources that emerged from the data were associated with relational and medical models and uncovered how participants constructed their experiences of therapeutic relationships with people experiencing psychosis in AMHS. The discourse processes that were employed in the construction of the dual subject position aided an ability to bridge the MH system and being alongside the person by enabling a juggling of dialectical tensions that have been evidenced in previous literature as well as within the ideological dilemmas uncovered in the current research analysis. The four interpretive repertoires highlight how therapeutic relationships are created and maintained despite systemic and interpersonal barriers that were discussed with regards to working in AMHS with people experiencing psychosis. This also illustrated importance for team working and support throughout the MDT to provide a holistic biopsychosocial approach to care through discourses that reflected a willingness to work inter-professional and intra-professionally. Counselling psychologist who took part in this study shared their enthusiasm for providing a person-centred approach to inpatient care by supporting nursing staff and psychiatric care by acting as mediators between different professions within the MDT. This mediation and willingness to work together as a team was also found in nurses talk. This research has added a counselling psychology voice to the body to research addressing inpatient care, MDT working and working with diagnostic labels such a psychosis, which is underrepresented. As such this research has contributed to the literature on the subject of the therapeutic relationship, tertiary care and working with psychosis and it is hoped that this thesis has added some insight into working in AMHS with people experiencing psychosis and that the future avenues of research identified above will be explored.

5.11. Reflexivity Part Three: The Researcher's Relationship with the Analysis and Discussion

The analytical process of this research was the part that I looked forward to the most, however in engaging with the data was overwhelming and intimidating. I found that I had to return to previous CDP literature to gather some wisdom about how others had managed this process and were reassured by Potter and Wetherell (1987) who stated that there will be many false starts and struggling with the data will occur and only through this struggle will patterns emerge – and they were not wrong! The interpretive repertoire table that I included in Appendix J was the third edition, due to these false starts. As explained in Chapter Four, how the final interpretive repertoires were presented was considered at great length because it did not seem to resemble other CDP research.

However, guided again by Potter and Wetherell (1987), and looking at further CDP research I could see that the findings often varied. I realised that as long as I could justify the way I presented my findings and I represented the data authentically I could follow my intuition and analytic process. Keeping the research question by my side throughout the analytic process was paramount in ensuring that I did not drift from the focus of this research, as the data was so rich and diverse that it would have been easy to wander off-topic. Part of the confusion in the analytic process was due to the dualistic, two-sided way the interpretive repertoires presented themselves with the ideological dilemmas apparent in each one. This confusion was partially cleared up when I started to follow my intuition and not try to stick to rigidly to what others have done before. Each interpretive repertoire could be perceived as a coin and each discourse is either side of that coin. Therefore, I decided to nest the conflictual and dialectical discourses that represented two sides of an ideological dilemma, within each interpretive repertoire.

Engaging in the research project throughout my counselling psychology training has highlighted how I have evolved throughout this path. My judgements about AMHS and idealism about the therapeutic relationship shaped and has been shaped by the findings of this research. The ideological dilemmas have enlightened me to the requirement for both a biomedical and therapeutic relationship approach, which is outlined in the biopsychosocial model that has featured in this work. Social constructionism and CDP enable an analysis of intersubjective co-construction and does view the researcher as a participant in data gathering, and I did accept my involvement and included it in the analysis where appropriate. This highlights that the researcher has as dual role of both researcher and participants, and therefore naturally reduces the classic objectivity of this kind of epistemological and methodological approach. My desire to advocate for the perceived *underdog* (the therapeutic relationship) created a bias in the way I delivered the interviews, and I can see how I led the participants into certain discursive avenues. I also acknowledge that I became too involved in the interview process and reflected that this was my overzealous to get started. In order to counter this, the importance of reflexivity in the research process is advised to ensure the data openly acknowledges this involvement. With this in mind, I reflected on my involvement as potential participant in my own research whilst replaying interviews. Hearing my involvement, even mild utterances and affirmations in speech could have influenced the interviewee's answers. This

reflection was also implemented during the transcription and analysis., as well as bring addressed in Section 5.8 that discusses the limitations of the research. I am now curious about how the data would have presented itself if I were less involved in the conversation or another researcher had conducted the interviews. This is a useful reflection to apply to future research.

The language used in writing this analysis and discussion was also reflected on action and reflected in action (Orlans and Scoyoc, 2008). I attempted to keep my words as non-pathologising as possible, I have noticed that my use of language was mixed with biomedical talk. When writing I noticed my choice of words and had to exercise some acceptance in also being a bridge between the MH system and the person or topic at hand. The use of supervision has been essential in being exposed to my biases and assumptions. My supervisor has guided my process to highlight the areas that I have denied or repressed, which has highlighted how defence mechanisms and resistances can also be apparent, not only in human-to-human relationships but also in human-to-research relationships. For instance, when sharing the analysis and preparing for the write-up of the discussion, it was highlighted to me how I could consider the literature that was presented in Chapter Two to support the findings in ways that I had not considered, and also how some of my findings varied from this previous literature and were to some extent new and unique.

Although when I started this research, I was keen to pursue a career in AMHS, further placement experiences have led me into working in High Intensity (HI) Improving Assess to Psychological Services (IAPT) setting. Having been engaged in this research whilst working in this setting I can see how this research could be applied to therapists working in IAPT and how they view the therapeutic relationship, which also seems to take a backseat to the CBT interventions that are adopted in the IAPT service. I feel that the topic of the therapeutic relationship does need to be advocated for, as it seems to be something that all HCP know is important but is not prioritised in psychological talk and in spaces where it could feature, like peer support, reflective practice and supervision. I believe I shall continue to highlight the therapeutic relationship in my clinical practice and this research project has taught me a great deal about engaging in research that I will consider in the future.

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Appendix A: Email Evidence for no Requirement for HRA Ethical Approval

LONDON METROPOLITAN UNIVERSITY

Lydia Baxter <lbb0017@my.londonmet.ac.uk>

RE: Queries - IRAS PRoject ID: 259893

STOICA, Emma (HEALTH RESEARCH AUTHORITY) <emmastoica@nhs.net> 27 March 2019 at 12:45
To: Lydia Baxter <lbb0017@my.londonmet.ac.uk>

Hi Lydia,

You will not need HRA approval (or NHS REC review) if you are not identifying / approaching potential participant through NHS channels e.g. by contacting AMHS sites, displaying posters on NHS premises, and/or attending team meetings with NHS staff to promote the study, AND the interviews are not conducted during participants' (NHS staff) NHS time.

You may need to revise the IRAS form A6-1 to be consistent with the information provided in subsequent sections. Currently it implies that there is NHS involvement.

Emma

Emma Stoical Senior Assessor – HRA Assessment

E: emmastoica@nhs.net; T: 02071048123

Appendix B: Research Poster

LONDON METROPOLITAN UNIVERSITY

THE THERAPEUTIC RELATIONSHIP WITH PEOPLE EXPERIENCING PSYCHOSIS IN ACUTE INPATIENT SETTINGS

Summary

I am conducting a research study as part of a Professional Doctorate in Counselling Psychology at London Metropolitan University. I am interested in exploring how Acute Mental Health staff make sense of the therapeutic relationship when working with people experiencing psychosis in Acute Inpatient Services.

What is involved?

- Initial meeting with a researcher to discuss the study.
- Sign a consent form to confirm that you are willingly taking part in the study
- Attend a face-to-face or online interview (approx. 1 hr)
- A £10 Amazon voucher will be offered to participants during the interview.

To take part in this study you must be:

- Individuals between the ages of 18-65
- Registered or Trainee Mental Health Nurse **or**
- Qualified or Trainee Counselling Psychologist
- Have at least 6 months experience working in Acute Inpatient Services
- Has, or has had, people experiencing psychosis on your caseload

If you are interested in finding out more about the study, please contact:

Lydia Baxter
Trainee Counselling Psychologist
Email: lbb0017@my.londonmet.ac.uk
Research supervisor: Dr Verity Di Mascio

This study has been reviewed and received ethical approval from London Metropolitan University Research Ethics Board.

Appendix C: Participant Information Sheet

LONDON METROPOLITAN UNIVERSITY

Version: 1
Date: 30/04/2018

Participant Information Sheet

Study title: Therapeutic relationships with people experiencing psychosis within an acute mental health care setting: A critical discursive evaluation

Authors: XXXXX XXXXXX XXXXX XXXXX

You are being invited to take part in a counselling psychology doctoral research study. Before you decide to take part, we would like to explain why this research is being undertaken. Please take your time to decide whether you would like to take part. Please feel free to ask if there is anything you do not understand and discuss it with others.

What is the purpose of this study?

- This study aims to gain a deeper understanding of how health care professionals (HCPs), specifically nurses and counselling psychologists, negotiate their therapeutic role within an acute mental health care setting, particularly with patients who are distressed due to experiencing psychotic symptoms.
- Previous research has highlighted that mental health nursing is challenging in these settings, but HCPs find ways of coping in order to maintain therapeutic relationships with their patients.
- Although much has been written about the theory of the therapeutic relationship and what it constitutes, previous research has identified that little is known about how HCPs adapt this theory to practice in everyday life on wards with patients. No research has explored this from a counselling psychology perspective.
- It is hoped that this study will shed light on how HCPs make sense of the concept of the therapeutic relationship in the context of acute care and bridge the gap between the current theory of the therapeutic relationship and being therapeutic in practice.

Why have I been invited?

You may have expressed an interest due to the posters that have been placed on social media, or someone you know has expressed that you might be interested. You have been selected because you are someone who has worked in acute mental health services for more than six months and has a caseload that includes patients who experience psychotic symptoms. Perhaps you have experience working with schizophrenia, or other diagnoses that experience psychotic symptoms. This is an invitation to discuss and share your experiences of working in this setting, with these types of patients.

Do I have to take part?

It is up to you to decide whether or not to take part in this study. If you do decide to take part, you are free to abstain from answering any questions, and you are free to withdraw at any time, without giving a reason

What happens when I take part?

You will be asked to sign a consent form to confirm your willingness to take part in the study, and a mutually convenient time and place will be arranged for you to meet with the researcher in an individual interview, either in person or using Skype telecommunications application software.

- The interview will be recorded using a password protected recording device or laptop, and it is estimated that the interview will last around one hour, but the time duration can vary and is entirely led by you. You will be asked some questions that focus on your experiences of the

therapeutic relationship, and how that concept fits into your role as a HCP in an acute mental health setting.

- The questions are not designed to test your knowledge, rather to gain a deeper understanding of your professional role. However, if there are any questions that you find challenging or difficult to answer, you can stop of a break or not answer them. It is important that you feel comfortable during the interview and the researcher will be respectful of this.

What are the possible disadvantaged and risks of taking part?

Taking part in this study is not anticipated to cause you any disadvantages or discomfort. The potential physical and/or psychological harm or distress will be the same as any experience in everyday life.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the study, it is hoped that this work will have a beneficial impact on how HCPs are perceived within the multi-disciplinary teams in which they work. It is also hoped that this research will inform how psychologist can support the nursing staff during reflective practice and supervision with challenging situation with patients experiencing psychotic symptoms. Results will be shared with participants in order to inform their professional work.

What if there is a problem?

If you have any complaints about the project, you can contact either the researcher (XXXXX XXXXX), the supervisor (XX XXXX XXXX), or the Doctorate in Counselling Psychology course leader (XXXXX XXXXX). Please see below for contact details.

Will my taking part in the study be kept confidential?

All the information that we collect from you will be kept strictly confidential. You will not be able to be identified or identifiable in any reports or publications. Your institution will also not be identified or identifiable. Audio recordings will be stored on a password protected pen drive and recording device, and transcriptions of these recordings will be anonymised using pseudonyms.

What will happen to the results of the research study?

The results will be analysed and written up in a doctoral thesis, which will be assessed in a London Metropolitan University exam, known as a viva. If successful, this research will also be published in a research journal. You will not be identifiable in any publication or report due to being anonymised.

Who reviewed the study?

The study was reviewed by London Metropolitan University Research Ethics Committee, and the Health Research Authority.
London Metropolitan University Research Ethics Committee approval received on: [date]
Health Research Authority approval received on: [date]

For any questions regarding this study please contact:

XXXXXXX XXXXX XXXXX

For any complaints or concerns, please contact

XXXX XXXXXX XXXXXXX

XXXXX XXXXXX XXXXXX

XXXXXX XXXX XXXXXX

Appendix D: Consent Form

LONDON METROPOLITAN UNIVERSITY

Ethics number: ……
Version: 1
Date: 30/04/2018

Participant consent form

Participant identification number: …….

Study title: Therapeutic relationships with people experiencing psychosis within an acute mental health care setting: A critical discursive evaluation

Authors: Lydia Baxter and Dr. Verity Di Mascio

Please read carefully and initial in the box if you consent to the statement.

1. I confirm that I have read the information sheet for the above study, and I have had time to consider the information, ask questions, and any questions have been answered satisfactorily ☐

2. I confirm that I am not currently experiencing symptoms of stress and/or burnout due to my nursing role. ☐

3. I understand that my involvement in this study is voluntary and I have the right to withdraw at any point without giving a reason. ☐

4. I understand that I can, at any point, withdraw my information and data, including audio recordings, and that this will result in all material contributed by me will be disposed of. ☐

5. I understand that I have the right to abstain from answering any questions, without giving a reason. ☐

6. I understand that my identity will be undetectable from participant information, and that all data, from recordings, transcriptions, and analysis, will be anonymised by using participant numbers and pseudonyms. ☐

7. I understand that audio recordings of the interviews that I take part in will be recorded using a password pretexted recording device and stored on a password pretexted pen drive. These recordings will be destroyed after the study, and the write-up has been completed. ☐

8. I understand that if I experience any distress during the interview, I can stop the interview and ask for additional support or guidance. ☐

9. I agree to take part in the study. ☐

Name of participant:	Date	Signature
…….	……	……
Name of the person taking consent:	Date:	Signature
…….	……	…….

Appendix E: London Metropolitan University Ethical Approval

Approval of ethics form for DProf in Counselling Psychology

From: Angela Loulopoulou (A.Loulopoulou@londonmet.ac.uk)

To: lydquine@yahoo.co.uk

Cc: v.dimascio@londonmet.ac.uk

Date: Friday, 15 February 2019, 12:34 GMT

Dear Lydia,

The Head of Research for the School of Social Sciences has approved your ethical approval application form. You can proceed with recruitment and data collection.

--
Kind Regards,

Angela

Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Ethics Review Committee for PG Psychology

Office hours 9.30-17.00 Tuesday to Thursday

Please email me if you would like an appointment, as I am not often at my desk.

Read my article at: http://www.tandf.co.uk/journals/banners/readmyarticle/ccpq.gif

Contact address:

London Metropolitan University
Room T6-20
Tower Building
166-220 Holloway Road
London N7 8DB
Tel: 0207 133 2667

Appendix F: Distress Protocol

LONDON METROPOLITAN UNIVERSITY

Distress protocol

Study title: Therapeutic relationships with people experiencing psychosis within an acute mental health care setting: A critical discursive evaluation.

This document is a guide to follow if participants in the above study become distressed during their participation in the interview. Before the participant takes part in the study, they will be required to sign a consent form, which asks for confirmation that the participant is not currently experiencing symptoms of stress and/or burnout due to their role as a nurse. This has been considered as a means to eliminate any undue distress to potential participants.
It is anticipated that participants will be not become distressed during the interview, however this cannot be totally assured. Therefore, a distress protocol has been devised to use in situations when distress is apparent. It is the researcher's responsibility to remain vigilant for the signs of distress in the participant, and to take action quickly in order to eliminate further distress in a safe and effective manner, and if necessary, to signpost the participant to further support.
The researcher is a trainee counselling psychologist, and as such is experienced in monitoring and managing situations where distress occurs.

Signs of distress:

1) Looking down, appearing uncomfortable
2) Shifting body positions
3) Fiddling with the hands or becoming restless
4) Taking big gasping breaths or signing alot
5) Becoming tearfulness
6) Voice becoming broken and/or difficulty speaking
7) Pressured/racing or confused speech
8) Looking pale or flushed
9) Expressing feeling faint or in pain
10) Becoming irritable or agitated

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed
4) If they express a desire to stop the interview, agree immediately and offer them a moment to collect themselves before they leave.
5) If there is concern that the participant is not safe to find their way home, offer them a chance to phone a family member or friend to assist them home, and stay with them until this person has arrived.
6) If the participant is not able to bring their levels of arousal down, breathing exercises and mindfulness exercises can be offers to manage this, with the participant's permission.
7) If the level of distress is high, agree with the participant to contact the NHS Employee Assistance Programme (EAP). This service is provided to all NHS staff at no cost and can offer advice and counselling for all NHS employees at no cost. Telephone: 0800 243 458, email; assistance@workplaceoptions.com.).
8) Participants who work outside of the NHS was be signposted to other emotional support resources, such the Samaritans (Tel:116 123), any in-house counselling services offered by their employer, or self-referral primary care counselling services.

Appendix G: Interview Schedule

Study title: Therapeutic relationships with people experiencing psychosis within an acute mental health care setting: A critical discursive evaluation

Research Questions:

How do mental health staff use discourses to construct and make sense of their therapeutic relationships with people experiencing in acute mental health settings (AMHS)?

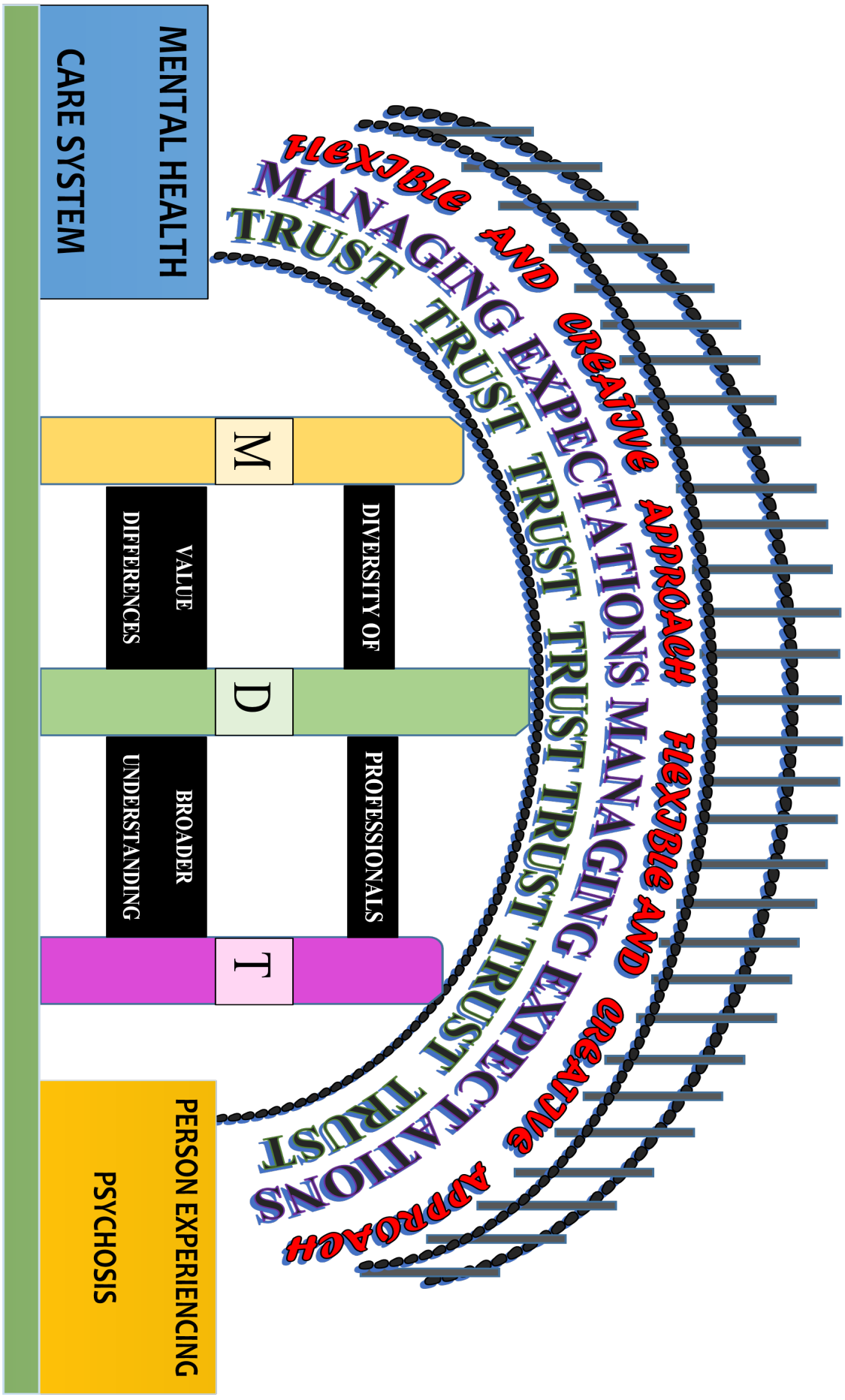
These are a number of questions that may form as a guide for the interviews:

1. What does being a mental health nurse (MHN)/counselling psychologist (CoP) mean to you?
2. What does the term "Therapeutic relationship" mean to you?
3. How do you make sense of the term 'therapeutic relationship'?
4. How do you make sense of working in an acute inpatient setting?
5. What does a therapeutic relationship on the wards look like for you?
6. Are there patients that you find easier to form a therapeutic relationship with?
7. Are there patients that you find harder to form a therapeutic relationship with?
8. How do you experience working with people experiencing psychosis?
9. What is involved in building therapeutic relationships with people experiencing psychosis?
10. What factors hinder the development of a therapeutic relationship with people experiencing psychosis?
11. What knowledge from your training do you draw from when working with people experiencing psychosis?
12. What personal qualities do you feel you have that help you when working with people who experience psychosis?
13. What do you find helps you do your job in acute mental health services?
14. Is there anything else that you feel is important when working in acute mental health services, and when working with cases of acute psychotic crisis?
15. Do you have reflective practice sessions and/or supervision with psychologists in your team?
16. What is useful and not useful about reflective practice/supervision sessions?
17. a) Do you have counselling psychologists in your team who provide reflective practice or supervision to ward staff?
    b). If so, how do you experience those sessions?
18. Are there other members of the MDT that you find useful to go to for help and advice? What do you like about what they offer you?
19. How do you find other HCP talk about the therapeutic relationship?
20. How do you find other HCP talk about people who experience psychosis?
21. How do you find other HCP talk about their job in AMHS?

Appendix H: Transcription Notation Code

[yeah] [okay]	Overlapping talk
(.)	Pause for < 1 second
(2) or (3)	Pause for 2 or 3 seconds
word word word word	Underlined text for emphasis
wo::rd	Colon indicates lengthened consonant or vowel
Word ↑ Word ↓	Up arrow indicates up pitch Down arrow indicates down pitch
<word>	Lengthened speech rate
>word<	Quickened speech rate
.hhh	Gasp or inbreath. 3 h's indicates normal duration less of more h's indicate longer or shorter duration
hhh	Sign or outbreath. 3 h's indicates normal duration less of more h's indicate longer or shorter duration

Appendix I: Map of Interpretive Repertoires and Discourses



Appendix J: Table of Interpretive Repertoires, Subject Positions and Ideological Dilemmas

Emerging interpretive repertoires (IR) about the therapeutic relationship (TR)	**Notes; subject positions (SP), ideological dilemmas (ID)**	**Quote**
Working/being with, relational discourse, relational awareness		
Alongside	IR being alongside the person – person-centred	**Cathy line 18:** [something] to do with (.) Alongside- being alongside the person
Authority and Power Not just another professional talking at them	They can see that I am alongside them IR - person-centred Just another professional talking to them (telling them what to do) IR - vertical relationship authority SP positioning self carefully as not being an authority	**Cathy line 26-27:** rather than I am yet another professional talking to them (.) Or talking at them as:: sometimes people might
Transference & Countertransference Provokes curiosity, tantalising story	IR – working with psychosis is not draining IR – working with psychosis is stimulating IR – really curious about their story	**Cathy line 388 – 396:** (.) .hhh (2) <it makes me feel> (2) .hh (2) curious (.) I am aware that might not be an emotions erm (.) Ah- well definitely not drained (h) [R: not drained yep] or tired (h) no not drained no (h) I- I-I-it's quite stimulating I find (.) Actually erm (.) Working with someone (.) Erm (.) With psychosis it erm (.) It <really> makes me curious about this story (.)
Transference & Countertransference Pt being guarded	IR – working with psychosis – sense of person being guarded (not forthcoming) IR – disappointing because the person is withholding the story – mixed feelings about that	**Cathy line 405 – 410:** erm (.) They almost seem like (.) <guarded> (.) Erm (.) Like you know they've no- not very forthcoming (.) To me (.) With me about about wha- what is going on for them (.) Erm and for this particular gentleman I have in mind it almost- it almost (h) feels quite disappointing in a way (h) [laughs together] "awww you're not really talking about- awww I was really hoping you would tell me this whole story about wha- what it is that's going on for you (.) Erm (.) So so it can be quite mixed actually it can be quite mixed
Relational awareness – awareness of self in relationship helps	IR - the relational awareness with the person.	**Cathy line 729 – 733:** so (.) mm mainly what what yeah what does that person (.) Could elicit from me (.) What I feel being with this person

therapeutic relationship (TR) with psychosis patient		(.) Erm (.) What has what has maybe some of my:: (.) :hh I wouldn't quite say I'd make interpretation like psychodynamic erm (.) Interpretations with the person but (2) what it really makes me think about (.) How interact with the person and then (.) And then to think about how they interact- how they then respond to me (.)
Biomedical language (words) and **person-centred narrative** (story)	Words are biomedical and highlight the rhetoric, but the story is about are and compassion ID – biomedical language and person-centred narrative IR – desire to help compassion – but within a biomedical discourse ("maybe they weren't treated correctly")	**Cathy line 877 – 887:** but there's that curiosity about what's gone on what's that person's story (.) which I find really lovely to hear (.) Within the nursing staff so they clearly care about this person about wh- wh- wh- why have they come here before why (.) Like (.) Maybe they weren't treated properly (.) You know so- so the language is still there (.) That it's based on the disease model (.) but the- but the narratives (.) Is still about (.) "gosh this person is still needing to be admitted to hospital" there's no frustration around that it's more to do with (.) We need to- we- we're doing something wrong lets- you know let's try and help this person to- to go back out again so there is that compassion if you like
Trauma root of MH concern Desire to relieve suffering	SP – I believe trauma is the root of mh concerns IR – desire to relieve struggling – broad moral codes that drive	**Cathy line 1008 – 1014:** psychosis that I've experienced but I think (.) Because the idea that I subscribe to is that everybody (.) Regardless of what diagnosis they receive if any (.) Have had some form of trauma in the past (.) and (.) So personally (.) Personal qualities (.) I think it's just (.) I do struggle I do find it difficult seeing people struggle↑ (.) If you like or umm (.) Not in distress per say (.) Just knowing that that person has had a shit life
SP - Not fixing	SP desire to hold lightly and work flexibly Desire to hold lightly	**Cathy line 1028 – 1040:** and looking at options rather kind of those fixed solutions and things like that that's definitely shifted (.) And I think that's come about (.) Through the training (.) My doctorate training (.) As well as maybe a couple of years before (.) When I worked in the ward but in a different capacity↑ umm (.) It's just thinking about things in terms of there's no right or wrong (.) It's- but more (.) It's a continual- (.) Well just use the terminology of dbt I guess (.) Effective or not effective and I just find that that's- that can be a really lovely way to interact to the person I am talking with (.) That I'm not here to judge them (.) I'm holding things lightly and I wonder if it might be helpful if you held think lightly too (.) [R: yep (.) So in a way you are modelling to them that holding lightly]

Flexible approach directive – nondirective Personality organisation = directive Psychosis – nondirective	Being directive – good for personality disorder, but not so good for psychosis	**Cathy 1058 – 1059:** and coaching (.) and is that possibly with people who have been or suspected of erm (.) Having some personality (.) [organisation]
Trust Mutual respect Best interest Normalising experiences of detention Gender differences	IR – trust; mutual respect IR - detained (taken their liberties away IR – can't always acknowledge – it's in their best interests IR – share experiences – normalise experience of detention IR – age of mh awareness – better now than it has been IR – gender – typical male groups "need to man up" more shame associated with MH	**Lara line 8 – 16:** I think for me is trust it takes a lot of time to build trust especially when we think of patients who are detained we are we have taken the liberties away from them and those moments they can't always acknowledge that there may be in their best interests so therapeutic relationships are built on trust mutual respect I suppose sometimes being able to therapeutically share experiences to sort of encourage people that what they're suffering is okay and we are coming into a really good age where we've got really good mental health awareness and it's really good to speak out but unfortunately especially within the typical male groups it isn't always okay to speak out its not okay to be upset and sort of "I need to man up" and working on a male ward I do face that almost daily
Being flexible Taking time Normalising	IR - taking time to build trust IR _ normalising – "it's okay to be upset IR – being flexible "thinking outside the box", one-to-ones not formal – go for a walk IR – trust IR – therapeutic alliance (working with – collaborative) IR – create safety (actively create safety)	**Lara line 18 – 22:** if I have someone who breaks down "well I just need to man up" so it's about taking that time to build that trust it's okay to to be upset previous experiences that I've had as a nurse being able to use them skills communication skills sometimes thinking outside the box that not all one-to-one need to be done on the ward in a formal sat down across the table even if it's going out for a walk with them sort of breaking down those barriers **Freya line 6 – 9:** the first thing that comes to my mind is trust (.) So (.) It's just establishing trust (.) The therapeutic alliance (.) You know just creating that sort of safety (.) for (.) A client or a patient (.) So I think this is the first thing that (.) Comes the mind (.)
Consistent, stable, unafraid	IR – consistent presence unafraid	**Diane, line 170:** it helps if you're not scared
Flexible / Creative	IR - classic moments in psychosis IR humour	**Diane line 503 – 515:** right (.) I mean you do get a lot of classic moments in psychosis like in that type of work on the wards (.) That's another reason that I like it actually (.) The humour in it [R: ah (.) The humour yes] I mean things like

	Being flexible - creative	that are absolutely hilarious (.) And there was another occasion as well in terms of creative thinking (.) it was a nurse a band five nurse (.) And there was a lady who used to talk a lot about jesus and jesus wants me to do this and that she was in the day area causing absolute chaos (.) You know tipping food and drinks and (.) The nurse was like "jesus wants you to go to your room come on let's go" and she went (.) so it's creative thinking and it sounds really funny saying it but its just creative thinking (.) Rather than let's get hold of this person and (.) Take them physically
MDT How medication compliance is dealt with MDT Emphasis on the biomedical approach – meds make them better What factors affect the TR? Personal factors – the patient IR - guardedness, suspicion, violence	IR – how medication non-compliance is worked with is questionable for diane Im restrained on bed IR – lack of creative thinking in the wider system Wider system = biomedical ethos Diane = personable, creative, TR approach System factors that affect TR with psychosis pts IR – medication. Will make you feel better vs "you're trying to kill me" ID – suspicion/paranoia and medication - poison?	**Diane line 471 – 494:** okay (.) Right well their factors are the guardedness (.) Suspicion "you're trying to kill me" erm (.) The violence (.) At times (.) I mean that's more relevant to picu I think (3) I suppose the wider system factors (.) Medication and how medication is worked with (.) "oh you take your medication" but at the same time the patient is saying (.) "you're trying to kill me" and that not being explored it's just being a matter of "here take your meds and you'll feel better" kind of thing (.) And yeah especially the more challenging patients that are sometimes just left to just think that but just take your meds (.) Erm (.) [R: their- their erm (.) Is it paranoia or let's call it suspicion (.)] yeah [R: about taking medication and especially if they have that type of- around (.) Pois- being poisoned] yeah [R: and then if you're saying (.) You know they're not going to take your word (.) It's not poison] P: yeah [R: because they're mind and their body sense is (.) "no this is- you're trying to kill me"] yeah [R: so-] how- how is that worked with so a lot of the time it's this patient is going to have im (.) And then the team come and she's restrained in her room on her bed (.) and given an injection (.) Erm but there are other ways of doing it (.) Creative thinking (.) Is quite important [R: so in the wider system sometimes there could be a lack of creative thinking yeah] Yes
Compassionate **Trust** Fulfilling for nurses Special connection	IR – 6 cs – compassionate (care, compassion, competence, communication, courage and commitment) IR – compassion --> trust	**Lara line 24 – 28:** but yeah I think mainly it's without sounding cliché but it goes back to your 6 Cs you need to be compassionate and with that comes the trust that they realise you have that you have only got their best interests (.) And also just so fulfilling as a nurse once you know you got that therapeutic relationship with somebody (.) And maybe they might not get on with other nurses that are the team

	IR – only have their best interests IR fulfilling for nurses to know you got that TR (sounds like a possession) IR – they might not get with another person (personal touch? Or special connection?)	
Nurse – someone on their side Subject position	SP – someone on their side.	**Lara line 85:** I think that helps that they feel that (.) It's sort of essentially someone on their side
Empathy	IR - empathy	**Lara line 94-96:** being really lonely being on the wards and that's you (.) And that's another aspect of the therapeutic relationship isn't it the umm (.) Being able to empathise with the other and seeing from their perspective
ID - Balance empathy with not knowing but being here for them	IR – be direct. Empathise but don't assume you know what they are going through. IR – I am here for you	**Lara line 100 – 104:** and (.) Straight away I'll put my hands up and I go "no I don't" (.) And I know that I am very lucky and I get to leave at the end of the day (.) however when I am here (.) I am here for you (.) For whatever you need me to do (.) And that sort of (.) I suppose because I don't skirt around the issue
Learning from the patient – good and bad situations	IR – open up communication so that nurse can learn from pt. IR – learning from every TR (good or bad) – helps develop nurse. IR _ good and bad TR – will she expand on this later?? Tr also helps the nurse (in their practice)	**Lara line 112 – 116:** let me know (.) So that then (.) Further up the line if we get to a situation where I need to potentially seclude you again (.) I can think back and go actually well no (.) He didn't feel this helped for x y and z reasons (.) And I suppose that (.) Every therapeutic relationship good or bad helps to develop you as the nurse going forward (.) Because it changes your practice properly every time (.) **Sarah line 30 – 31:** although (.) Erm I think it's just (.) Remembering that having that good working relationship is gonna not only help them but its gonna help you (.) In your everyday work as well
Use of self	IR – use of self (Wosket) bringing self to the TR	**Lara line 222 – 224**: and I often sort of say "right, I've not got my nurse head on now, I've got my head on, I've got my mum head on, actually there is no answer for this (.) But let's just roll with it, let's just see where it goes

Being available	Being available to those who need it (not time wasters?) Qualification (nursing) give legitimacy to hear frightening (sensitive) material and know how to answer it. ID - should (line 9) judgement around expectations of the job and insinuation that might be some nurses who are not capable (this features later in the interview *Privilege to hold frightening material and knowledge of how to deal with it* ***Discourse resources of the nursing subject position*** *– nurses can get close to sensitive material* ***Discourse processes*** *to align with how to receive and process such material (line 9) "should"*	**Valerie lines 7 – 11:** being (.) Being available to people who really need it erm (.) I think that the qualification gives you a certain legitimacy with people that they don't need to be frightened to say certain things because you not just someone at a bus stop or their cousin or their aunt or something you're you're a trained mental health professionals should be capable of hearing what they have to say and knowing how to answer them I think
Kind Do no harm Consistent It may not work – risk of being unsuccessful	IR – kind and patient (from the first time you meet them IR – do no harm IR – didn't make me more stressed IR – consistent IR – not granted that it will work	**Valerie line 372 – 388:** so I'm not saying "aww I won't speak to you until I know that you- you're all balanced out" but you know you start to (.) Be that kind and patient person from the time that you meet them (.) and hopefully when they (.) Let's say when they come round- come to you know wake- wake up a bit from the experience that they're having (.) Then they'll recognise you and go "right okay well this person didn't cause me any harm this person didn't make me more stressed this person has been <u>consistent</u> (.) in the way that they speak to me I think" [R: so that that's all part of being- of having a therapeutic relationship (.) So consistence] be consistent [R: and not causing me any stress (.) You said then this person is not causing any stress was that what you were saying (.) Or am I misinterpreted what you said (3)] yeah (.) You're not granted it's going to work like I've said before (.) There's people that you've match with

MDT In training – learning for the team	IR – gained experience working with psychosis in placements in training – the team input was more beneficial for learning IR – managing risk IR – supporting person IR – admission to AMHS is not always beneficial or necessary IR a pts norm – individualised consideration regarding admission	**Lara line 378 – 386:** erm (.) And during my second year my placement was with erm (.) A mental health liaison team (.) Working really closely with the a & e department and I think that was probably my best (.) Sort of experience of seeing psychosis in its various forms in terms of sort of drug induced erm natural (.) Sort of like organic erm (.) And from then actually probably (2) the- the feedback and input I got from the team that I was in (.) Was more beneficial for me managing risk (.) And soft of how (.) How we support that person (.) Being able to sort of acknowledged that for some people (.) Even if they are suffering from psychosis and admission is not always necessary for them it isn't always beneficial (.) And sort of working out what patients (.) Norm was (.)
Non-diagnostic Not reading diagnosis to meet the individual	Not reading diagnosis to really get to know person (without diagnosis)	**Lara line 756 – 760:** and my regular mentor was put with another gentleman who refused for me to (.) Read erm any of the patient's notes prior to me meeting them↑ erm with a view to (.) Not looking at diagnosis and I do think that's probably one of the (.) The best thing ever heard
Non-judgemental crime – non-crime	IR – non-judgmental – treat the mh concern without judgment of crime-no crime (forensic) IR – just sitting with them IR – leaving the door open Theme - working with	**Lara line 786 – 798:** [erm (.) I sort of] make it quite clear especially if we get people come in that got (.) Erm sort of forensic or (.) They know that they've got something sort of looming in the background I will say to them (.) It is none of my concern (.) I do not want to know what you have done (.) or what you think you have done (.) that isn't (.) Why you're here why you're here is for (.) X, y, and z so there is no judgement and that doesn't have any standing on what's going on (.) and I sort of think that's the way you hav- (.) Well (.) You don't have to but I think that's the way I sort of (.) Look at it
Be with Sitting with them willingness to be with	IR – sitting with them, talking, caring	**Lara line 880 – 881:** just sitting with them (.) And watching them sort of come back and be like "okay (.) Something just happened (.) Do you want to talk about it" and sort of leaving that door open
Consistency to build engagement	IR – consistency builds patient engagement	**Lara line 922 – 924:** with someone who's got psychosis erm (.) Which I suppose can be a challenge in terms of (3) if a really good therapeutic relationship has been (.) Been- built through consistency may be that patient will only engage with that one nurse
Managing psychosis - delusions in context	IR – understanding context of delusions –	**Lara line 1007 – 1010:** maybe that delusion is built on (.) Previous (.) Sexual abuse or you have (.) Some sort of (.) Erm sort of history there or (.) If it is just a delusion (.) That

Validation of emotional experience	previous sexual abuse history	actually you probably- when you become quite well be maybe horrified of what you said or what you've done
Compassion	IR - aware of what people come to the ward with. There's a reason for their behaviours – compassion. IR – safeguarding	**Lara line 1015 – 1019:** "well this has obviously come from somewhere where is this come from?" And then before I've realised I'm down the safeguarding (2) sort of rabbit hole of (.) Is this happened is that happened and actually probably (.) In reality not a lot of it has but (.) These are the reasons for (.) Triggers (.) It can be sort of abuse and things like that so we do have to be very mindful of (2) everybody does come with this this this package we're not always aware of it
Rapport Flexibility Complexity	IR - rapport IR – boundaries that shouldn't be crossed IR - flexibility Quite complicated	**Sarah line 13 – 17:** erm so (.) I think what comes to mind is a good (.) A good relationship with someone building that rapport I think (.) Being therapeutic also means being professional as well (.) So there are- there are boundaries (.) That shouldn't be crossed (.) They remaining therapeutic (.) But (.) There are also things that need to be flexible to make <u>sure</u> that it's still therapeutic it's quite complicated rea[lly]
MDT Strong team But high turnover of staff	IR – like a strong team atmosphere IR- high turnout of staff IR therefore difficult to deliver consistent high standard of care – difficult for staff and patients	**Sarah line 68 – 71:** erm I think (.) You have to be strong team and there's a high turnover of staff so (.) I think (.) When you don't have a strong team there's inconsistencies in the team that makes it difficult to deliver (.) A high standard of care erm (.) Because from one shift to another you'll be doing different things and I think that's really difficult not only for staff but for the young people (.) They don't know where they're at necessarily
Humour	Humour – sharing humour / sharing a bit of a joke	**Sarah line 96 – 100:** I think it looks like (.) Well in first interactions it's a case of (.) Getting to know that patient r: mmm (.) and (.) I think- I think therapeutic relationships can be built on like a humour (.) Sharing a similar sense of humour and I think that's (.) That's how often it can be built up by sharing a bit of a joke
Mutuality - willingness	Mutual willingness IR - mutual willingness - pt and nurse willing to engage with each other	**Sarah line 111 – 112:** erm (.) But generally all it will be the (.) The patient and the nurse are willing to engage with each other
ID - Informal vs boundaries **Flexible approach**	Informal IR – informal, activities together	**Sarah line 119 – 122:** and then just informal-informal just you know (.) Sitting and (.) Having a bit of a laugh or sitting doing activities together that (.) You know just pass the time it's

	IR - sometimes informal with time and sometimes more boundaried depends on the person – being flexible	not about therapeutic input it's just about spending that time **Sarah line 129 – 137:** yeah (.) Sometimes you'll go into a one-to-one with a patient and know that you might be there for (.) Quite a while if you don't set a boundary and say like you've got twenty minutes (.) We're going to do this in the twenty minutes and stick really closely to those time restrictions otherwise you'll be there for evermore (.) but others it will be a bit more like (.) You can be a bit more informal and (.) Yeah you just get a sense for when maybe they've had enough of going though all the serious things and (.) Move of from that and say right (.) Either they might get distressed or they just (.) Get bored
<u>IR – managing unpredictability with</u> **<u>ID - Boundaried and flexible approach</u>**	ID - predictable vs flexible IR - unpredictability is difficult to manage IR – with psychosis – they're in their own mental place – IR - they (psychosis pts) are more disinhibited more risky IR – therefore more difficult to manage unpredictability IR - knowing the patient whether to impose time restrictions. Depends on pt IR - sometimes boundaries are good for the pt so that they know what to expect – predictability IR – flexible, adjust and adapt IR – not too intense – gentle approach IR – space to be creative	**Sarah line 68 – 71:** erm (.) But also I think something that is difficult and will always be difficult is the unpredictability (.) People with psychosis they (.) You know they're in their own mental place and they maybe don't (.) Have as many (.) They're more disinhibited and they're more risky (.) Which can be difficult to manage (.) Never manage unpredictability **Sarah line 141 – 148:** so yeah I think it's just a general feel and also again it's about knowing (.) Knowing a patient and whether you have to set those time restrictions (.) those boundaries (.) and sometimes even if (.) Even if they don't necessarily need those time restrictions it's sometimes good to say "right this is going to be a twenty minute session" just so that they've got only twenty minutes to get through and then (.) And then they can carry on with their day **Sarah line 153 – 157:** yeah adjust and adapt and that's fine (.) And then others might want a couple of one-to-one throughout the day and honestly it depends on (.) How much time you have as the nurse or (.) How much time anybody else has but maybe you can do- if you've got quite a bit of (.) Quite a bit to go through then you can say "maybe we can do a bit in the morning (.) And a bit in the afternoon" bit after bit so it's not too intense (.) **Freya line 22 – 37:** [and- and] yeah (.) And what else erm (.) Yeah also it allowed me to be creative (.) So there's something about (.) The option of knowing that someone is in hospital forever someone who is a chronic patients (.) Someone who is going to stay here (.) Probably for most of the life so it's (.) That gave me creativity because it allowed me to establish a trust and I saw this patient every other day (.) And I was able to create like a very strong

	IR – boundaried structured environment allowed for creative approach --> comforting so enables creativity SP – likes to be a creative person	alliance and then (.) Work with- (.) Work with that sort of boundaried structured environment (.) to produce more creative (.) Therapeutic (.) Techniques↑ (.) and kind of use them↑ in a strange way because it was very safe anyway↑ so there is nothing (.) You knew these people would go back and (.) They're highly- you know closely monitored nothing is going to (.) Like no real (.) Events are going to happen and no one is try and attempt suicide or no one is going to- so you kind of have that knowledge (.) Working with them so that's very comforting and creates more (.) It- yeah it gives me as the therapist the confidence to be a little more creative I think (.)
Psychosis = need for **reassurance and validation**	IR – felt sense of a need in people with schizophrenia – that they wish to connect, be reassured, validated, heard ID – common belief that schizophrenia might be a diagnosis to steer away from, but Freya wished to go towards that SP – a person who really "sees" the person and wishes to meet their needs	**Freya line 171 – 181:** and in a way I mean I feel like (.) I mean they (2) they are like- they deep down I feel like a lot of people with this diagnosis they really do want to connect to someone [...] like there is a need for them to (.) To be believed trusted validated reassured (.) So I felt that there was a lot of room for me even though (.) You wouldn't think that (.) Like something- like people would kind of (.) Want is steer clear of from [...] in general this- this diagnosis I think (.) erm (.) But I felt like kind of tuning into that need to be heard or for them to be validated was (.) was was rewarding in the end (.)
Countertransference Psychosis difficult to work with Feeling forceful with negative symptoms	IR – psychosis negative symptoms – difficult to work with SP – feeling I became forceful, badger-y nagg-y when with a person with negative symptoms	**Freya line 192 – 198:** yes (.) Those with negative- negative symptoms↑ so lots those people who had (.) Especially older men who had (.) Negative symptoms of schizophrenia or psychosis (.) Were very difficult because they were completely uninterested (2) in (.) In forming a relationship or (.) You know this kind of (.) Complete aversion so I had to be very forceful- not forceful kind of resili- badger-y and really like- I felt kind of nagg-y (.) and this was (.) This wasn't something is comfortable with
Empathy and compassion Realisation of the fragility of the brain	IR – destabilising experience working with psychosis IR – fragility of the human brain	**Freya line 226 – 233:** but I think that working with psychosis bring a lot of- (.) It can be very destabilising (.) It can be very (.) Coz I think every therapist (.) Gets to that point when they understand the fragility of the human brain↑ and they get really really in touch with (.) How fragile the human brain is and how your mind is just (.) A very fickle thing and then (.) Because we all live- we all like I think that (.) They know exactly what is going on in their head [...]

		but actually (.) You kind of get (.) You- you (.) Time and time again you are reminded that the human brain is very (.) Fragile and it is capable of so much (.) We still don't understand [so]
Countertransference Being with psychosis feels spacey, scary dissociative, mania	Being with psychosis IR – dissociative IR - spacey IR - scary This is me bringing the interviews together into a focus group idea Being with psychosis IR – sense of mania, energy of the psychosis	**Freya line 252 – 253:** yeah I think it could be very dissociative I think it could be (.) It could be spacey of it could be scary (.) Based on what this person is coming [with] **Freya line 269 – 281:** [R: yeah exactly (.) And that spacey feelings as well you described earlier that kind of (.) Erm (.) I'm just drawing from another interview that I've already done with someone (.) I wonder if I (2) she said that (.) It feels almost a little bit like a mania in yourself (.) You sort of feel a bit heightened especially with those more positive symptoms patients exhibited you can tend to feel (.) A little bit on the manic side as well (.) And you come away feeling quite exhausted and erm (.) Like on a high [...] you can relate to that as well (.)] mmmhhh definitely (.) Again depending on the energy behind that psychosis like if it's someone who's (.) Kind of kind of chronic a little bit more residual (.) It different to someone who's in the heights of their psychotic episode
Countertransference Feeling incriminated due to paranoia and delusions	Being with psychosis IR - paranoid suspicious – feeling incriminated by the pt – not pleasant	**Freya line 160 - 255:** so it does depend on (.) It does (.) Like yeah it does- it maybe a little anxiety provoking of this person is actually (.) Dangerous (.) So it the person's actually like (.) You know (.) Kind of threatening to to (.) Kill themselves or to- thinks that you are an enemy (.) Or thinks that you are part of the CIA and out to get him or you know (.) This kind of system is in place this paranoid system (.) And you're part of that (.) Other enemy that that's (.) Not a pleasant feeling because you feel quite (.) Erm (.) You feel incriminated (.)
Countertransference and defence mechanisms Intellectualising – to try to make sense of it. Defence against alienation of psychosis	**A defence against the alienation/unusualness of psychosis** IR – alienation around psychosis ID – defence against alienation - making meaning of the experiences of psychosis to decode it – to make sense of it.	**Freya line 288 – 306:** family and they haven't felt this way they never (.) Seen that before so there's (.) An alienation around [...] So that makes it (.) A little more difficult but at the same time (.) When someone is (.) I mean I try to make meaning of it so I try to use the content and I think this is a defence mechanism↑ [R: okay] like using the content as a (.) As a way of (.) As an "in"- like trying to understand the narrative the story that- that (.) Symbols behind it [...] like trying to link it to their lives (.) You know so try- so this- this I think keeps me a little safer↑ (.) from the- the emo- emotional erm (2) you know one-to-one (.) Intensity [R: yes] I think this and I'm trying to look at their (.) Their psychotic experience as something that's (.) Meaningful and something that's (.) Erm you

		know something that I could decode (.) [R: yeah] and understand (laughs)
Not being part of the system able to access the person more readily (as a trainee)	What helps build TR SP – not being part of the system – helps build TR IR - structure	**Freya line 341 – 345:** erm (.) I think (.) You know I think it's first of all it's- (.) it's structure (.) so having psychotherapy in the right time and ending at the right time and having a very (.) clear structure with them (.) helps erm (.) what also helps is- is just (2) kind of emancipating myself from the hospital in a way like trying to be like "I'm not (.) part of this (.) I am an individual"
Honesty **Authenticity**	IR – honesty IR - feeding back what the pt said IR – just open and feeding back all the time ***Discourse processes -*** *the word "just" (47) to denote the simplicity in this and perhaps insinuating the complexity that is produced by other people who are less honest?* ***Discourse processes -*** *the word actually (49) – as if it was expected that you wouldn't hear them. This insinuates that the available discourse resource might be that nurses don't listen, perhaps?*	**Valerie line 38 – 49:** being honest all the time also if you start from that position I think you can- you can make mistakes because at least your being honest [...] you know "I thought you were calling me because (.) You know (2) you know for whatever reason but in actual fact you contacted me for this reason" [...] just being open and feeding back all the time [...] and that way people know that you actually heard them
Working with psychosis **Not well enough to build TR** **Managing delusions**	IR – state of acute psychosis IR – not well enough to work with IR – not well enough to build TR with ID - being honest and not being honest – around working with delusions Pt delusions about being romantically involved with male nurse	**Valerie line 404 – 455:** I think (.) Staff not trying lots of different ways (.) You know if you just try one (.) You know I've got one way of approaching people and if that hasn't worked (.) Then- that (.) You know (.) Drawing a summary around that person like they're not well enough to- to work with anybody (.) A person being really really unwell (2) you know that difficult to build a relationship with somebody who is just not well enough (.) [R: yeah oh right so they're just not well enough] they're just not well enough (.) You know they just can't (.).[R: and that's another question is is there any patient or are there any patients that you find really hard to build a relationship so that that I think you're alluding to people who are just not well enough what has not been well enough actually

	IR – damaging (emotionally) to challenge delusions IR – not able to understand IR – honesty and consistency with facts doesn't work – because your denying their reality – halting the relationship IR – do we fib? Do we say he's on another ward? IR – instead end up giving approval to her opinion – don't engage with conversation and don't enrich it, IR – don't agree with delusion don't disagree, deflect and distract instead IR – different shifts will have different staff – some willing to toe the party line, others will just tell the truth ***Discourse resources*** – *delusions, honesty, consistency, hurt them,* ***Discourse processes*** – *fib (lying lite), different shifts – different staff – some willing to toe the party line, others will just tell the truth*	mean] yeah (.) Somebody who (.) In a- in a state of acute psychosis who just (.) They believe their experience over and above anything else so if you keep saying to somebody- so say for example erm (2) I had a patient who had- had (.) In her head (.) Developed a romantic relationship with a member of staff and that member of staff- hhh it was such a shame because it was a really great member of staff (.) Who would have been absolutely super to work with this particular patient but because she had decided that they were (.) Having a romantic relationship (.) You know he obviously went above-and-beyond to show that that wasn't the case but in actual fact he ended up being removed from the ward and working somewhere else because that lady cou- was fixated on the fact that they were going to be together and they were a couple and [R: right] and still to this day believes that they have a connection and is emotionally hurt by the fact that she's not spending time him (.) And (.) You know she's not going to be able to (.) Understand that that's not what happened because the more that you say that to her and say (.) "well look that man's married and he has children" [...] "and he's your nurse and he cares for you but he cares about you- your health erm (.) And he couldn't possibly be in a relationship with you" that's even more damaging to keep repeating that to her was really painful because she has in her head that- it's a real thing [...] so if you're trying to speak to people (2) and be honest and be consistent (.) But what you're saying isn't something that they want to accept (.) The knack of halting the relationship for a while because you're trying to refuse- you're denying them their reality and you're seen (.) you know "how has that person slept overnight?" "how did the behaviour stay?" "how were they feeling yesterday when I wasn't there?" "and now that I am here do we (.) Do we fib?" you know do we just (.) Do we almost give (xxx) approval to the opinion and say "oh well maybe just say he's had to go work on another ward today" so just don't engage in conversation about it certainly don't (2) enrich it by drawing her into a discussion about what has happened or you know between them you don't (.) You know I'm not saying play along with the hallucination or having a delusion that they've got (.) But sometimes they're- you know to break that person's heart again by reminding

		them (.) "no you are not in a relationship-" you know it hurts when you say that
Managing difficult/traumatic material **Trauma-focused**	IR – if someone trusts you enough to tell you something hideous IR – hold the information, just know it, witness it IR – what do you want me to do with that info, inform police IR – as a person – how am I going to cope with that separately --> the nurse is a person the work impacts you as a person. IR – if im dismissive or don't acknowledge it correctly – what if I don't manage it well? Fear Seeking help from psychology team/ psychologist Discourse resources – trauma, sensitive material, feeling the weight of that part of the job, Discourse processes – how am I going to cope, seeking help psychology	**Valerie line 756 – 780:** because (.) If someone's trusted you enough to tell you something hideous (.) An experience that they've had (.) knowing that you (.) Can hold that information (.) And communicate to them that you heard it (.) And that you know what do you want me to do with the fact (.) do you want me to help you phone the police do you want me to just know it (.) You know do you want me t- you know (.) Yeah what- what do you as a patient want me to do with what you've just told me (.) And I think that one of the things I was never tested on in real terms in my training- I suppose you were observed all the time (.) But there's not a lot of erm (.) Like role playing type things when someone comes in and says (.) You know if there had been that kind of thing in your training coz you can't ever prepare yourself for what you're going to feel when you find out somebody's grandfather did something to them (.) you know you just need to (.) To- to know in yourself how you'd think about it first "what would I do if somebody told me that" (.) how am I- how am I as a person going to cope with that separately but how am I going to cope with it right there in the moment because at that point what's really important is how I respond to it for the patient if I'm dismissive of it if I don't really (.) Acknowledge it correctly (.) You know (.) And when you go in to meet the (.) Psychology and you say "look (.) This patient with me x y and z (.) How- (.) What would you recommend in do to help them what is your (.) Therapeutic angle at the moment how are you coping helping them cope with it so we can be consistent in the treatment that we're offering
The TR as a means to experience the person experiencing psychosis	Embodied connection = trust. Person to person IR - felt sense IR – trust Rapport Genuineness Understanding IR - genuineness can be felt by patient	**Diane line 13 – 30**: right okay (.) So (.) I think in terms of (.) Trust (.) I think in terms of (.) Rapport (.) Erm genuineness understanding erm (.) And clients- patients picking up on that (.) as well [R: right] coz I think- I think when you're genuine they can pick up on it even if (.) Their psychosis (.) Is present (.) Yeah in my experience anyway (.) [so when you explain that to me you're saying it with your- with your hands here as if it's a body to body communication] yeah yeah [R: and that's how you- it's a felt sense] yes [R: it that right?] it is definitely a felt sense [R: right] yeah (.) I know (.) When (.) Someone is (.) Is connecting with me (.) Even when there's psychosis present I know there's a connection there [R: yep] so that- that makes it a therapeutic relationship (.)

		So even in my nursing role (.) It's a therapeutic relationship (.)
The TR as a means to experience the person experiencing psychosis	IR - trauma focus – history that has affected how they cope IR – psychosis as a way that the brain has adapted to trauma in their history IR – talking about their history ID – but not wanting to upset them further SP – shifting "blame" of mh illness onto their history IR – how the brain coped with history IR – trauma as a brain changer SP – what version of you do you want me to see today? = tears. Seeing the person as multi-faceted – acknowledging complexity can be upsetting. SP – one foot in the medical camp SP & ID – but acknowledging that they brain structure is different because of trauma - perhaps	**Valerie line 864 – 926:** Well actually you deal with in on a case-by-case basis you have to consider when you meet someone who is suffering from psychosis or a psychotic episode (.) How much do I need to know (.) About what the experience was that led them to <u>have</u> this (.) Illness (.) because not very many people end up just being psychotic for no reason (.) [R: what led (.) And that's what you meant about the trauma focused] the trauma yes so if I start trying to see somebody (.) Now how did this happen? (.) They might have been in the system- I mean I'm meeting people who've been at the (xxxx xxxx) hospital for fifteen twenty years (.) and a lot of things would have happened on the ward outside the ward in their lives that have just <u>added</u> to the trauma that they've got (.) [R: right (.) Trauma] you know because you can read (.) If somebody's been in hospital for a very very long time and they suffer from psychosis the chances are I am not going to open their notes and in the front is going to be filled with a very nice crib sheet of (.) Things that happened to that person so you're going to try to find (.) Get (2) you're trying to get as much information as you need but you again are really creating a safe space for that person you know I want to get to know them but will I cause damage will I upset them by saying to them (.) What happens do you- I mean I've had people in tears because I've said to them "what version of you would you like me to meet today" (.) coz we're all different people every single day depending on whether you've got out of bed late whether or not you've had your heart broken (.) There might be somebody in your life that is very sick (.) You know you could be about to go into a job interview (.) You know we all present different versions of ourselves [...] yeah (.) their brain has adapted to help them cope (.) this is how it's adapted [R: exactly] that's not (.) That's not (.) You know they didn't change their eye colour (.) You know they didn't change you know (.) But their brain has (.) I suppose there's a little bit of me that has a half a foot in the medical camp because I look at it and go (.) Look the organic brain structure has changed [...] or didn't develop because of the trauma that that person has experienced so I <u>have</u> to give (.) Some (.) Credit to the fact that (.) If you've been smashed in the backside out

		of heroin for year (.) “oh your dopamine receptors are screwed” (.)
Biomedical discourse, diagnosis, wellness-unwell		
Biomedical narrative – black and white rationale, Misinforming	IR – biomedical narrative can misinform or not tell whole truth to people in order to manipulate them. Do they then feel that they will no recover unless the fall in line with the biomedical advice, which is misinforming/limiting their choices? ID – for patients when biomedical talk is used without consideration to the person as a whole. Follow suit and get well or don’t do what we say and get worse/stay the same	**Cathy line 637 – 643:** it's not is not giving (.) It’s not (.) Misinforming the person [R: oh right okay not misinforming] yeah (.) Yeah so say for example if if a person is being told “you're not going home (.) Unless if you take the medication” it leaves no wriggle room really [R: yes] so the person (.) Impression the person is being given (.) Is “oh (.) So (.) If I don’t take medication (.) It means I’m not gonna to recover (.)-
Diagnosis governs way of relating (this is mentioned more elsewhere pull out from other themes)	IR - diagnosis label governs the way of relating. Way of relating is dictated by diagnosis.	**Cathy line 928 – 931:** and (.) I notice that the way that this person was talked out in the office became something quite different (.) [R: ohh] it was- it became something along the lines of (.) She's a get out very quickly (.) [erm]
Biomedical narrative can influence the TR	IR – TR depends on the biomedical narrative – doesn’t take much to change opinions of the person.	**Cathy line 949 – 957:** [R: so- so you would say that perhaps your experience of other health care professional’s talk about the concept of the therapeutic relationship (.) Their concept of talking about erm (.) Different patients erm (.) Depends on that biomedical narrative and categorise] it does (.) Yeah it did feel that it was driven by that [R: okay] driven by the biomedical (.) Yeah [R: okay] erm (.) I mean not- not all of the nursing staff (.) Did this (.) It just- just several (.) But it was enough (.) Erm to have (.) It was enough to make that second narrative alive↑ (.)
Delusions trigger “behaviours”	IR – triggers of delusions --> increase their behaviours (reactions to things). Increase behaviours is mh talk relating to cbt framework (I think). Is there a misbehaviours	**Lara line 996 – 998:** increase their behaviours [...] and- and sort of their reactions to things (.)

	connotation – like the patient is acting out/acting up?	
Attachment difficulties	Attachment difficulties – make TR building easier Psychosis is not seen as potentially affected by attachment styles. Is it viewed as more organic/biological?	**Sarah line 474 – 475:** talking about personality disorder pts But in terms of building a therapeutic relationship I would say that they were easier (.) Because of the attachment difficulty
Diagnosis General knowledge – societal assumptions about psychosis affect our ideas about this diagnosis Discourse resources	Media. Society assumptions biases	**Sarah line 487 – 498:** when you think about mental health and you think about nursing of somebody who is really poorly a lot of the time (.) Even the average person would think of somebody that's (.) That's psychotic without realising that's maybe what it is (.) A lot people of somebody that really [inaudible] somebody that's seeing things that's not there (.) You know erm (.) Hearing voices [...] I think that's (.) A lot of people (.) I think it's getting better now (.) But I think traditionally a lot of people would have thought of mental health as someone who is poorly with mental health issues as that (.) So I think a lot of nurses I think that's (.) That's what they think of isn't it so I think (.) Caring for those (.) Those psychosis patients (.) I think people do look forward to (.) Particularly on my ward I know that that (.) Coz
Being curious	IR– curiosity/ being curious	**Freya line 475 – 479:** it's usual experience (.) Erm (.) And another quality would be to- to I guess (.) To just (.) Outside of my training I think (.) Just curiosity is just endless curiosity (.) I think this is the only (.) I mean this is the only thing that gonna make- be the difference between a good practitioner (.) And not a good one because it's (.) It's- it's just a (.) A domain- a- a- a career where you're constantly have- you have to learn it not (.)
Unwell	IR – mix of pts IR & sp -unwell. Acutely unwell IR - separated from society *(that is a historical idea)* IR & sp – unable to function on their own ***Historical discourse resources*** **-** *historical*	**Valerie line 137 – 142:** I worked in (.) Rehab wards where you have a real mixture (.) Of acutely unwell individuals but they're not they're not so unwell that they need to be (.) Separated from society completely but they are also not well enough to function on their own (.) And maybe you know the services that we got up in xxxx where I am [...] you know there's just not enough supported accommodation (.) Facilities to have them there (.) And they've been un hospital so long that's their home (.)

	ideas mh unwell = can't function ***Systemic discourse resources*** *– there are issues that contribute to people's ability to function* (not enough supported accommodation)	
Flexible time with patients		
(AMHS) pts are in-house - not restricted to once-a-week	Acute setting - to build a TR you need time and in acute settings they are in-house IR - you can see them often	**Cathy line 42:** time in in in effect, in a sense to <build> the relationship with the person (.) And it is <not> limited to -it's not restricted to (.) Seeing them once a week
24-hour contact with staff	Accessibility	**Cathy line 93:** which is different from (.) The person who >is already on the ward< (.) And having that 24-hour contact essentially (.) with staff (.)
Doesn't have to be an hour	Flexible time	**Cathy line 55:** and it doesn't have to be an hour and I- I- I really (.) Value that (.) Someone on the ward it's not (.) You know there's no pressure that they have come in especially to see you and it's got to be an hour or an hour and a half or whatever [R: right] it can be (.) To whatever the person can tolerate really (.) Erm you know it could be (.) Only 10 minutes or it could be (.) 15 minutes (.) Enough time (.) For I- I feel (.) Enough time for me to show my face and to <show that> what I said before (.) >being alongside that person that it that there's no pressure to sit there are talk< for an hour (.) Which I know can really freak people out sometimes.
Drip -drip approach flexibility Open approach	IR – slow approach (drip- drip) little and often approach and retreat – working with fear, paranoia and scepticism (like with a young or mistrustful horse) IR – flexibility in duration and frequency of sessions	**Cathy line 455 – 457:** definitely (.) A very (.) Drip drip- slow dripping sort of approach [R: ah ha] Definitely (.) Being flexible about (.) When you see them

Flexibility What other factors	IR – grabbing the opportunity when you can (flexibility IR – difficult to predict what factors have shaped how the person is	**Cathy line 469 – 472:** knowing that I- I just knew- you just- (.) So that's the other factor you just need to grab the opportunity when you can get it↑ because you just (.) You don't know it's very difficult to tell (.) Going back to what I was saying before you- you it's just very difficult to tell sometimes what factors have shaped how that person is (.)
Going at their pace Alongside	IR – factors – going at their pace	**Cathy line 478:** going at the person's pace and this will go along the lines of that
Flexible	IR – flexible with time. With people with psychosis nothing ever goes to plan	**Cathy line 481 – 487:** and I think also (.) To s:: (.) You know (2) as much time or as little time as- (.) And you have to really play it by ear in the moment I- .hh I have never (.) Gone to see a person (.) Erm who has been diagnosed with- with psychosis or suspected of (.) Umm and anything comes plan [...] I've always gone in- I've learnt now (h) [laughing together] before I did TR- go and try going with an agenda but I've learnt now you just need to hol- you have to learn to hold it really lightly (.)
Bridging gaps and balancing dialectics		
Bridging gap – ward staff agenda and persons needs	IR – bridging the gap between ward staff agenda and what the person needs. Referrals come through with staff opinion – psychologist has to go to person to find their experiences and understanding and meet them where they are at ID - bridging the gap between staff agenda and what the person needs IR – not creating resistance by going alongside the person's experience to encourage an intervention	**Cathy line 490 – 498:** they referral came through saying "oh: he need anger management" [...] okay so (.) That was clearly an agenda that my colleagues want me to have in going to see him so I I had in my mind (.) I went there (.) And that really wasn't wha- what he was wanting and I think if I try to push it↑ (.) Erm (.) I would have lost him (.) [R: right] He wouldn't- I don't think we would have gotten that moment where he (.) Volunteered that information to me "I'm gonna go on an out of area placement (.) Can I see you again before I go"
Balancing the expectations/needs of the system vs the person ***Discourse resources*** *– the mh professions in AMHS are likely to represent / expected to*	IR – trust – TR can't be therapeutic until trust is present SP – I'm friendly (id – but not your friend) – clear distinction between friendly but not friend...a pleasant	**Valerie line 14 – 20:** to me hmm (.) Its a lot of things (.) I'm friendly but I'm not your friend and this could be a clear distinction there between being someone that someone can trust and trust takes a long time to build so I don't think it's the therapeutic relationship until the person that you're working (.) With in some way has (.) Maybe tested you to see if you can

represent something unpleasant, against what the pt wants. ***Discourse processes*** *– positioning self away from the act of deciding by adding "as a profession (17)* **Rupture and repair (did I mention this is psychodynamic perspectives of the TR in the clr?)** *In hindsight I would have liked to ask: what does the system impose that is not in line with what the person wants? & how does the hcp build trust when they represent the system that is not trusted?*	person with personal distance) IR – being tested by pt – can you be trusted SP – pt disenchanted with mh system ID – (contradicts the trusting element) – going against the pts wishes. IR & sp – "decision as a profession" - the decision is not made by the individual person/nurse, agentic state. ID - the decision belongs to the profession (system) does not ally with what the person wants (or perhaps goes against what the nurse wants to be (sp – a person someone can trust). Is this a way that hcp might manage the contradiction between their expectations of their role, what the system requires and what the person wants/needs? IR - the uniform represents the system profession and something they don't really like yet being a nurse/therapeutic relationship is about being someone to trust and being available – *very dialectic!*	be if you can be (.) If you can be trusted cos I think a lot of people who have experienced being in the mental health system (.) Hmm a bit disenchanted with it you know maybe we've made decisions as a profession that don't ally with what the person might want in their life **[...]** and so especially when you've got the uniform on you might represent something that they really don't like
Bridging the needs of the system and the person **Representing something they don't want (detainment) and**	***Discourse resources around really listening*** *might be a way to managing / bridge that gap between representing the system (**discourse resources** of the system – take away liberties, confine, disempower) and being*	**Valerie line 21 – 38:** So yeah therapeutic relationship is one of patience (.) Hmm really listening to what the person has to say and not just looking for what you need for your notes [...] but really listening to what the person says hmm (.) Because they might be trying to tell you something (.) But they can't come straight out with it so (.) They act in certain ways to explain how their feeling and what they're going through of what they have gone through

attempting to help really listening **Listening (really listening)**	*alongside what the person wants* ***(discourses processes*** *of both system restrictions; not be able to provide the person with what they want - whilst also listening to what the person doesn't want. Knowing and holding both.* ***Paradoxical subject position*** IR – really listening to what the person has to say (not just what you need for you notes – *tick box exercise*) IR – act in ways that explain feelings/what they're going through/gone through How does she reconcile representing something they don't really like/allying with something they don't want in their life and wanting to help? Listening, really listening and that might involve not providing them with what they want **Is it a want vs need thing?** IR - listening and paraphrasing, checking back with the pt – did I get that right? *ID - really listening to their narrative but also being allied with what they don't want (line 17 valerie)*	in the therapeutic relationship means that I really have to listen and watch (.) A person to get to know them (.) And I have to communicate that to them so that they (.) So that they know that I'm paying attention [R: how do you do that how do you communicate to them that you're really listening] try and (.) You report back to somebody on something that they just said is a kind of a classic so (.) What I'm hearing is this is that right and then asking them did I get that right so not just assuming that you know even if it's really simple (.) Stuff that you just so I get that right is that what you meant because that gives them the option to correct you instead of you just assuming oh yeah yeah l read that right you know maybe- maybe l didn't
Detention SP – how nurses are perceived by pts	IR- empathy (it must feel so lonely) IR - detention	**Lara line 87 – 89:** [because I] I could only imagine it must feel so lonely (.) Especially in cases where is it detention that you've- you've been detained to this place (.) Your family can't come and go as you please you can't come and go as you please you need to (.) Build your

	IR- build your allies in hospital make allies of the nurses Is detention another way to isolate to weaken pt so that you can get them alongside? SP – their perception of us (nurses)	allies (.) [...] so I suppose that that's how maybe our patients perceive us nurses .hhh
Being honest in the face of detaining/seclusion	IR – being real about "not getting where pt is coming from IR – behaviours escalate IR – seclusion (isolation)	**Lara line 106 – 108:** I just get (.) That's why I get it I don't- I don't get where you're coming from because I haven't lived it (.) Especially if we've got situations where (.) Behaviours escalated and needed seclusion
Conscientiousness	IR – helpful to know history, details and context of psychosis. IR - conscientiousness about sensitivities to their triggers IR - in acute phase – consistency and brief reassurance can help later on IR – being there – being a presence is enough	**Sarah line 172 – 182:** and I think (.) Obviously knowing a bit about the history of what sort of psychotic features they are having is really important (.) If they- if they are really paranoid or if they're thinking like aliens or things like that [...] having those sorts of things in the back of your mind so knowing (.) Knowing to sort of avoid those topics maybe not talk about technology things like that if it's to do with technology maybe (.) Avoid speaking about the phone and (.) Phone access when they're initially there because it's (.) I don't know it's (.) It is- it is very difficult and I think in the first few days of a psychosis (.) It can be really challenging to erm (.) Build that rapport (.) But (.) I think it's just (.) Consistently going to then and saying "I'm here" "we've taking care of you" reminding them of where they are as well coz sometimes they're confused
AMHS environment – restrictive or holding.		
Knowing they are on the ward	Restrictive environment but easier to see often ID – environment is restrictive and makes patient accessible The restrictive environment provides freedom around time to see the pt ID – environment restrictive for patient but freedom for hcp	**Cathy line 45:** they are on the ward even though that's a:: restrictive environment in a way (.) I also know that (.) That then- >and I can see them the next day as well<

Offers opportunity for intense input	Nature of how the wards environment IR - opportunity for intensive input IR - flexible time - due to them being there, there is no pressure to use an hour of time – it could be shorter Patient accessibility = time of therapeutic session can vary to suit both patient and hcp	**Cathy line 54 - 56**: I like to think that that's an <opportunity> for the erm [tut] (.) Intensive↑ kind of input↑ intensive sort of interaction with the person and it doesn't have to be an hour
Flexible timing of sessions	IR flexible time – what the person can tolerate IR flexible timing of sessions – no pressure can follow the person/patient	**Cathy line 60 – 64:** it can be (.) To whatever the person can tolerate really (.) Erm you know it could be (.) Only 10 minutes or it could be (.) 15 minutes (.) Enough time (.) For I- I feel (.) Enough time for me to show my face and to <show that> what I said before (.) >being alongside that person that it that there's no pressure to sit there are talk< for an hour (.) Which I know can really freak people out sometimes.
Holding environment Structure Holding environment	IR – holding environment - positive aspect of AMHS. Add being flexible = good AMHS – setting IR – structure IR – closely supervised IR – holding environment IR – strong sense of community – being part of something, belonging	**Cathy line 514 – 519:** you like about working in acute (.) Inpatient settings in that there is that availability to be flexible because they are there and you are there and so there's that so- so it seems to me that working with (.) Someone (.) Suffer- erm you know erm:: maybe not suffering is the right word but their their coping with these symptoms erm and you're saying that that erm that (.) Being able to be flexible with the duration and also the timing of of their appointments with you erm (.) That kind of lends itself in that environment (.) [...] I guess one of the things I like about that setting is the structure↑ (.) So there was a lot of structure and the kind of (.) Just being- working in a hospital very structured so you kind of have working hours and it's very- (.) Everyone agrees to do this kind of work and you're very closely supervised so I think (.) It was very- it give me structure when I needed to start off as- as a practitioner (.) It was a holding environment in its own way it also had lots of- you kind of developed a strong community- a sense of community- sense of being part of something↑ which is something I <u>lack now</u> as- as a trainee counselling psychologist doing random placement so for me it's (.) It's something that (.) Yeah gave me a sense of belonging and this was <u>very</u> important (.) In- in - in my work (.)

Medication inhibits TR	IR – medication hinders TR. ID - biomedical interventions hinder relational interventions	**Cathy line 563 – 566:** I think when it's to do with medication [...] erm (.) I think if:: the team as a whole (2) inadvertently↑(.) Perhaps↑ (.) Sometimes inadvertently↑ place a lot of emphasis on (.) >medication compliance
SP – pt aggrieved by **medication compliance** conditions to discharge	ID – no discharge until there was medication compliance. Do as you're told and you can leave. Relates to the medical model SP – the person w/psychosis can be aggrieved by not being discharged until they are medication compliant IR – medical model – medication compliance	**Cathy line 5 – 575:** (.) A lot of (.) Emphasis on medication compliance (.) We weren't discharging unless we can be <u>sure</u> that you're taking a medication and the person feels very (.) quite aggrieved by that (.) and it can- it's a very <u>significant</u> (.) You k- erm medical model the narrative is very significantly linked to that
Hard to be non-disease model approach, working in setting that is characteristically biomedical disease model focused	SP – non-disease model focused person working in a biomedical disease focused setting SP – not wanting to be bound by one position of the other (non-disease model – disease model)	**Cathy line 657 – 659:** I'm .hhh (.) Because it can be really difficult being a (.) Non disease model focused person (.) working in (.) A setting that is (.) Characteristically biomedical disease focused (.) **Cathy line 665:** erm (.) I just don't feel- because otherwise I think I (.) I would feel really bound by it↑
Dealing with the unexpected	IR – dealing with pt who are experiencing the unexpected - detainment	**Lara line 54 – 55:** because we're in a very stressful situation (.) And (.) That person when they got up in the morning may never have thought for a million years that they were going to be detained
Detention	IR- empathy (it must feel so lonely) IR - detention IR- build your allies in hospital make allies of the nurses Is detention another way to isolate to weaken pt so that you can get them alongside? SP - their perception of us (nurses)	**Lara line 87 – 91:** because I] I could only imagine it must feel so lonely (.) Especially in cases where is it detention that you've- you've been detained to this place (.) Your family can't come and go as you please you can't come and go as you please you need to (.) Build your allies (.) so I suppose that that's how maybe our patients perceive us nurses .hhh

Opening dialogue	IR engaging in difficult conversations without open curiosity	**Lara line 109 – 110:** and they're coming out well you don't know what it's like you've shut me in a room you've done this (.) I should be able to go yeah you're right I don't know tell me what it's like
Different types of nurses Stereotypes Discourse resources Nurse Rachet	IR – breaking down stereotypes Discourse resources – nurses like nurse Ratchet in one flew over the cuckoo's nest.	**Lara line 196 – 198:** [yes (.) I think] (.) The hard thing with that (.) Is (.) Like you say breaking down all of their- their stereotypes of what they think (.) When you say mental health they probably think of (.) Nurses such as like the one- the one that [flew over the cuckoo's nest]
Different types of nurses – willing vs unwilling	IR - nurses willingness to work with patients vs not getting "off their bums" (line 148) ***Discourse resources*** – *different types of nurses* ***Discourse process of subject positioning*** – *self and others into various categories* *Valerie expressing frustration with the other members of staff who are unwilling to "go above and beyond" (idealism)* it's a willingness issue rather than being aligned IR – burnout - some staff that "don't, won't or can't" IR - it takes time to work with pts who need help to calm down and make things safe	**Valerie line 154 – 163:** I think with that its willingness (.) [R: willingness] rather than aligned (.) There's a lot of burnout but there's also (.) You know you would get it in an office you know you got some staff (.) That will go above and beyond and do what they're supposed be paid for (.) In the eight and a half or thirteen hours that they're paid for (.) And you've got the staff that don't won't or can't (.) those- what's really difficult I think is if you have one patient or two patients (.) Who are having a really bad day (.) And because of the time (.) That it takes up and the amount of staff that sometimes it takes to (.) Locate that person to bring them back down from the experience that they're having to (.) You know calm them down and make is safe (.)
Patients match with you Right nurse for each patient A nurse for every job Person with psychosis – just not well enough to build TR	IR – pts you match with IR – patients pick staff they connect with IR – make a connection with (pts --> staff) IR – go to nurse depending on what they need (paperwork or talk etc)	**Valerie 397 – 409:** patients will definitely go to different nurses with many different things with the need some paperwork done (.) They'll go to one nurse whereas when they want to talk about something traumatic that's happened to them they'll go to another [...] I think (.) Staff not trying lots of different ways (.) You know if you just try one (.) You know I've got one way of approaching people and if that hasn't worked (.) Then- that (.) You know (.) Drawing a summary around that person like they're not well enough to- to work with anybody (.) A person being really really unwell (2) you know that difficult

	IR – psychosis pt – just not well enough to build TR	to build a relationship with somebody who is just not well enough (.) [R: yeah oh right so they're just not well enough]they're just not well enough (.) You know they just can't (.)
Seclusion Hate about AMHS	IR - seclusion, administering medication against person's will	**Lara line 244 – 246**: asked is what you find challenging about working in acute but I think you are saying already about how the erm (.) You know how you have to (.) Sometimes be ermm (.) Involved in seclusion and erm (.) Administering medication and things like that against someone's will
Hate about AMHS Seclusion and medication under restraint Break trust??	IR - things I hate, seclusion and medicating under restraint	**Lara line 250 – 257**: I would always say whenever we had students I always say the two things I hate about my job (.) Is IMs under restraint (.) [R: ohh] because it's just absolutely horrific but it has to [R: say that again the what] sorry the IMs the intramuscular injections that be (.) Essentially (.) Sedating someone [R: ahh gosh yes] against- whilst they're in a restraint (.) And having to seclude people (.)
Hate seclusion and meds under restraint	SP - seclusion and meds under restraint – feel sorry not something my team are very good at...we do not take it lightly	**Lara line 258 – 262**: really part of my job that afterwards and I'm very (.) Sort of my heart's in my throat when I'm talking to them saying I'm really sorry that we've had to do this (.) But it's been for like either your safety or other people's safety (.) And I do always make a point of telling patients it's not a decision that- (.) I mean I can't speak for other nurses (.) But my team are very good that we do not take lightly
Managing "behaviours" SP – medication under restraint = not taken lightly	IR – behaviours (what do they mean by that?). When people do things on the ward that are disruptive? SP – nurses don't take their interventions lightly...it's serious!	**Lara line 264 – 267**: it's something that we (.) Discuss sort of (.) Because we can see the behaviour happening (.) Sort of (.) If this- if this behaviour continues how are we gonna manage it (.) [R: yeah] and it's not something that we do lightly
Getting to know them Supportive Hope	IR – like getting to know them & supporting IR - being there for people seeing them get better IR - hope	**Sarah line 51 – 53:** oh erm (.) I just love my job (.) I'm still at that point that I love it erm (.) What I like about inpatients is I really like spending time with the young people my patients (.) And getting to know them and supporting them on a daily basis that is something that I do (.) Really love (.) And I think (.) Although it's a really tricky time for these young people and (.) Alot of them it's their first time in inpatients (.) And some of them are extremely young (.) And I think (.) I just- I just like being there for people and I like- I like seeing them get better (.) And I think (.) Particularly in CAMHS that's why I like CAMHS so much (.) Is because (2) with young

		people there is more hope than in adult services↑
MDT – strong cohesive IR - strong team atmosphere ID – but difficult to deliver care	IR – like a strong team atmosphere But IR - high turnout of staff IR therefore difficult to deliver consistent high standard of care – difficult for staff and patients	**Sarah line 62 – 66:** erm I think (.) You have to be strong team and there's a high turnover of staff so (.) I think (.) When you don't have a strong team there's inconsistencies in the team that makes it difficult to deliver (.) A high standard of care erm (.) Because from one shift to another you'll be doing different things and I think that's really difficult not only for staff but for the young people (.) They don't know where they're at necessarily
MDT inconsistency in team --> risk	MDT theme inconsistency in team --> risk IR – different perspectives within different professions	**Diane line 187:** erm (.) Yeah I mean psychiatrists (.) We're quite lucky on my ward in that the doctors we've had (.) Have been erm quite aware of social context and quiet reflective and you know not so (.) Power (.) **[**R: orientated] orientated (.) So (.) But then there have been times they have been clashes actually I'm thinking of (.) One example in the past (.) A lady was saying (.) So she had psychosis she was saying that her (.) Partner had been hitting her (.) and the psychiatrist- he was- he was a (.) Brilliant doctor actually erm (.) But he was saying "yeah that's what she says when she's unwell" (.) and then my thing was but maybe she's lost her (.) Inhibitions **(.)** because she unwell and that's why she now saying it (.) [R: oh I see] yeah **[**so she's divulging some (.) Evidence] yes [...] [R: so you offered a different perspective] yeah and it wasn't viewed that way (.) And then the comeback was "well I've met him and..." My thing was "well that doesn't matter that you've met him and you think it's alright because coming out of her mouth is this stuff so it needs to be explored a bit more (.)
MDT inconsistencies	IR – different views of the therapeutic relationship MDT inconsistencies	**Diane line 234:** yeah (.) But we- we are quite a good team on picu erm (.) In terms of doctors in terms of managers all being (.) Really good ward managers (.) Yeah it's the nursing staff that tend to vary (.) The most **[**R: okay (.) And with that the nursing staff varying does there err (2) how they talk about the concept of the therapeutic relationship does that change as well (.) Is it just as varied between people as it is between professionals]
MDT inconsistencies	IR – staff perceive pt in terms of like and dislike	**Diane line 277:** yeah well, some people talk about it in terms of like and dislike (.) Like "she doesn't like me" or "I don't like that patient" (.)

Creative approach = better TR	IR - in acute settings – they're more scared and you have to be a bit more creative to build trs	**Sarah line 600 – 607**: in their relaxed- own habitat also (.) For me in hospital (.) In my (.) In my setting sometimes it's their first time in hospital they're often scared as well so it's (.) They're not relaxed they're scared they're also experiencing all these things that are really scary really difficult to manage [...] they've got me asking them their favourite colour maybe it's not- [R: (laughs) yeah "can I trust this woman?"] yeah I think you're right like (.) You know in their own environment those questions can come a bit more easily whereas in a clinical environment you've got to be a bit more creative (.)
MDT AMHS ritualistic environment Team working ID - part of the system but not part of the system	IR - AMHS – ritualistic environment = IR holding environment IR - close contact with the team ID close contact with team but sp not part of the system (freya line 345) ID – part of the system but not part of the system contradiction	**Freya line 492 – 502**: So- but at the same time I was being constantly supervised because I was part of that team (.) So it was- it was (.) There was very ritualistic- (.) It's very interesting because working at a psychiatric hospital is a very- very ritualistic experience so there was a lot of like (.) Rounds (.) You know (.) Morning- you know morning [...]erm (.) So there was a lot like (.) That in place and that also (.) Brought me in close contact with the people I was working with so this was in itself a very (.) Holding environment↑ (.) and I could come up and say whatever I need to and whatever I (.) And- and ask the question they needed to immediately I guess (.)
AMHS – stressful environment	AMHS – stressful environment	**Valerie line 58 – 59:** yeah I mean err I work where I work at the moment is a twelve bed locked unit hmm (.) It's a very stressful environment
MDT AMHS – hinders TR Depends who's working Types of nurses Flexible balanced	What hinder/helps the TR on AMHS Depends on the shift/who's working **IR** – micromanagement – flexibility vs rigidity **IR** – some nurse-in-charge – turns a blind eye to smoking vs that's not part of what we do **SP** – types of nurses – flexible/balanced – yes man - micromanager **ID** – friendly but not your friend	**Valerie line 265 – 290:** it depends on what shift you're on [...] you might have somebody who's in charge of the shift for the day and they're a little bit more (.) Yeah you go and escort that patient that's fine knowing fine (.) Knowing fine well that when you go out that patient is going to smoke [...] and then you'll get other people in charge who will say "oh no you can't take that patient out for just a cigarette that's not that's not part of what we do here [...] so again it's the minute it's the micromanagement in (.) In the unit on a certain day (.) Erm [R: makes it difficult] it does make it difficult (.) and the thing is you don't want to split your own team (.) you know you don't want to be the one that all the patients like just because you say yes all the time (.) you know because that's not a therapeutic relationship that's (.) That's you just been a yes-man [R: which also isn't therapeutic

	ID – I want you to not want to ever see me again – make a meaningful bond with the person, but also want to never see me again. Close and meaningful but not attached? ***Discourse resources*** – *types of nurses, micromanagement, lack of flexibility = difficult shift. Smoking ban,* ***Discourse processes*** – *helps/hinders depends on shift (depends on how flexible others are).* ***SP*** **-** *subject positioning staff in categories – making things difficult or not.*	because it's like you said right at the start you're friendly but you're not their friend I think that was- (.) That summed it up really beautifully] it's hard- and that's hard but I kind of want people to (.) You know "I want you to not want to ever see me again" (.) You know if I- if we do a job right you never gonna see me again
AMHS – it's an institutional bubble	She is referring to ed but perhaps all AMHS **AMHS – "it's an institutionalised bubble"** IR – leave your illness behind you when you get discharged IR – in hospital you don't have to be part of to-and-fro of normal day / responsibilities	**Valerie line 296 – 305:** you know so almost- because it's a bubble you being inside an acute ward is erm (.) It is a bubble it's an institutionalised bubble [where] (.) you know your heating is on your shower works your food gets put in front of you there's clean sheets for you (.) You know you don't <u>have</u> to (.) Be part of the normal (.) To-and-fro of a normal day you don't <u>have</u> those responsibilities for a while (.) erm (.) And it does- it paints a slightly otherworldly (.) Environment (.) And you kinda want people to leave there if- if they can with- with eating disorders (.) You know to leave as much of them- that in in the ward when you get discharge that's what the relationship should help with (.)
Staff differ in their management of delusions (same as diane)	IR – no consistency due to staff members difference in management	**Valerie line 471 – 472:** or yesterday I was on to do this and then I wasn't (.) So it's kind of (.) They're left in the situation were there's no consistency for them
Honesty of pts feelings (not the facts) **Compassion and empathy**	You don't want to do it to them IR – delusions are real experiences, real emotions, experienced in the physical body – legitimating their experience	**Valerie line 482 – 498** you don't want to do it to them (.) "oh don't be daft" or- (.) Anything like that (.) Especially if you know it's a delusion that this person will play out again every single day (.) There isn't really a lot I can say that gonna suddenly erase from their memory [...] these are real emotions real experiences that they are- that they have in their <u>physical self</u> (.) (.) they feel that they are connected to another

	IR – believe so strongly IR – can't erase with a few distractions IR – line 494 understand how you feel – empathy IR – line 497 distraction **ID – line 492 – highlights how distractions alone don't work, adding empathy and honesty of feelings (rather than honesty of the facts)** ***Discourse resources*** *– can't erase delusions, real experiences, real emotions, have in physical self – highlights the solid physical nature of emotions and delusions,* ***Discourse processes*** *– can't erase with distraction, but adding empathic statements (valerie line 494 & 497) can make a difference.*	human being (.) They <u>believe</u> something so strongly (.) That- (.) Who- I can't just erase that with half a dozen words and a puzzle book and a walk around the garden (.) [...] but to say to somebody (.) "well (.) Well look it might be a while before you see him again you know but I understand how you feel" or "I'm really sorry you feel that way today what else are we gonna do (.) If you're not gonna get to see him today what else would you like instead?" (.)
Type of nurse to work with psychosis/mh nurse	SP – don't like seeing distress, very rewarding to be there (humanistic) ID – trainings was 50-50 altruistic – egoistic (helping others because I get something out of it) – it serves me to feel good to help others. IR – stand next to them alongside ***Discourse resources*** *– humanistic discourse, altruistic and egoistic.* ***Discourse processes*** *- combining opposite (egoistic & altruistic) egoism and altruism is described as opposite things, but here valerie combines them to*	**Valerie line 646– 658:** and I don't like seeing people in distress (2) and it's a very very very rewarding feeling to be there for someone when they're in distress (.) For me my training was completely (.) Absolutely 50-50 altruistic egoistic I am very much compelled to help people (.) Yeah and it makes me feel good to do it (.) [R: that's the egoistic bit] oh completely (.) You know if you make something- you make dinner and it was amazing you're like "ahhh" (.) But I'm not the right person for everybody (.) So I don't think I can nurse everybody (.) To the same degree (.) I don't think I can (.) You know not everybody (.) Is going to enjoy my style of nursing [R: yeah] you know and that's okay as long as I haven't done anything damaging but yeah it's erm (.) I've done a number of different jobs in the life and they've offered me different levels of satisfaction but this is (.) Is real life (.) [R: yeah you helping somebody- you stand next to them whilst they sort out their life (2)

	outline the mutually benefit she experiences through helping others. She gets something out of it. Higher self - will to help.	
Types of nurse - old school nurses	IR - authoritative IR – medicate IR – risk assessments based on risk (not strengths) ***Discourse resources*** *– old school nursing, tapping into historical and media ideas of nurses and mh nursing* ***Discourse processes*** *– positioning authoritativeness and medication orientation, and perhaps not gathering the big picture/systemic issues for the pt, as old school*	**Valerie line 661– 670:** well (.) I've certainly seen a lot of authoritative (.) Nursing (.) There's a bit of a change of the guard at the moment erm in scotland (.) There was a (.) A deal that if you started your training and qualified by I think 1996 (.) If you did 30 years then that was it you (.) You could retire at fifty-five [R: right] and so there are a lot of people that I met during my training that I would come in and "I'm just on the way out doll I've done my time" you know erm (.) And they had a kind of (.) The old school way of nursing was (.) Medicate you know write a risk assessment based on risk not on a person's strengths (.) (.) and an authority- there's been a very sort of (.) "I tell you what time it happens" there is still an element of that but it's shifting (.)
Diplomatic style nurse	Eating disorders in acute setting – stand-alone unit – heavily invested – quite a unique little bubble IR – related to the diplomatic management style nursing	**Valerie line 672– 676:** more of the kind of (.) Diplomatic management style coming along (.) Because I think we do (.) Have like in the acute setting I'm in now and the forensic setting actually (.) They were very well- heavily invested erm (.) There was a lot of money (.) I mean our unit is a stand-alone eating disorders unit which within mental health is quite rare (.) To have I mean you don't have one just for psychosis and one for depression you know it's quite unique to have this little bubble (.)
Types of nurse – diplomatic style	Types of nurse – the diplomatic management style IR – sit and talk together IR – bed management – turn them over, get a bed free	**Valerie line 678 – 685:** you know I think between (.) The different wards that I've been on that there has been more of a kind of management- the team (.) Hopefully will sit and talk together (.) A more democratic approach but the (.) I think the nurse's job is to be the patient's voice because I think sometimes the pressures of management have got (.) You know have been counting the money that is being spent (.) [R: is that a different style the "be the patient's voice" is that a different style or that part of the diplomatic style do you think] I think that's a different style I think because a diplomatic would be (.) You know "we've got x amount of beds" like a restaurant "what do we

		need to turn them over what do we need to do to get that bed free"
Types of nurses – "be the pts voice"	IR – I think the nurse's job is to be the patients voice IR – holistic type SP – I am here for the patient (said x2). SP – my biggest concern (valerie line 702-703) – voice for the quite pt Discourse resources – holism – seeing big picture – looking for the holes – what have we missed Discourse processes – subject positioning using holistic discourses to position self as partly diplomat (Valerie line 693) and mainly "pts voice" nurse (throughout).	**Valerie line 692– 704: [**R: so you have the authoritative and the old school we have the diplomatic] old school (.) A bit of diplomatic (.) I think there's definitely more erm (.) [R:be the patient's voice] definitely more holistic style that's coming out [...] so people like I am (.) I am here for the patient (.) You know I am here for the patient (.) I am- am (3) a get- yeah I get that I fall into that category coz I've sat in on a few MDT meetings so far (.) And you know they talk about the most extreme cases and things are going on and the people who are causing the most raucous in the ward [R: yep] and they say erm (.) And they about to close the meeting and I say "oh actually if you don't mind (.) My biggest concern is the patient that just got up to the highest BMI ever and has been on pass and we're just about to let them go (.) That's the person I'm most worried about because they've gone really quiet (.)
Expectations (patient and staff) driven by cultural biomedical discourse resources		
Biomedical expectations "appear that". Subject positioning in opposition to the "fixing doctor"	IR – biomedical (would not want to appear that way to patient) IR – biomedical discourse; something wrong with you and this will fix you Environment offers flexibility that the hcp uses to be flexible. SP in opposition to the biomedical approach - vary my approach according to the person	**Cathy line 71 - 77:** I wouldn't want to appear that (.) I am there (.) In erm sort of talking therapies equivalent to (.) Erm a doctor if you like an- and being able to give a prescription and (.) And you know "here you go, you've come in because something's wrong and here's something to fix you" you know I wouldn't want to appear (.) To- to give that impression and I and I think (.) And I think that's one of the nice things about (.) The fact that the person's on the ward and (.) And for the psychologist >for me as a psychologist< it gives me the opportunity to vary it >according to that person's tastes
Person's expectations about length of therapy sessions	IR – community person's expectations = when coming in for therapy, one-hour appointment	**Cathy line 90-91**: (.) I find that people's expectations then because they've come in for an appointment, they expe- they have a certain level of expectation

Person's expectations about length of therapy sessions	IR - inpatient person's expectations when on the ward is varied length of therapy session	**Cathy line 93:** which is different from (.) The person who >is already on the ward<
The setting shapes pts expectations	Amhs IR the setting shapes the person's expectations	**Cathy line 96 - 97:** it's the person's expectations as well it shapes their expectations depending on what setting they are in
Pts expectations to be fixed (is a challenge)	IR – fixed (person's expectations) AMHS not conducive to phych input. IR – the AMHS challenge to work alongside the person's expectations that can be contradictory to psychological therapy. Is this an emerging ID?	**Cathy line 103 – 110**: is the person's expectations to- to <be fixed in some way↓>
Prescribe – expectations driven by biomedical discourses and historical/ cultural context	IR - managing person's expectations from discourse resources. SP – of hcp bridging the person's expectations and what they know to be possible in AMHS. Being in hospital What a psychologist does The word managing sounds dialectic (juggle) if could also indicated a vertical relationship in that the participant is superior to the persons expectations. IR - manage – this challenge may be a source of frustration for hcp Hospital – biomedical expectations (discourse resources from society that are used by the person to understand their environment) id - managing discourse	**Cathy line 118:** I think the challenge is managing that person's expectation (.) What is it that they expect from being (.) In hospital whatever in hospital means for them (.) Err particularly if it's their first couple of times in hospital .hh and they might <not be> and also and/or they're not familiar with what a psychologist does for example (.) Erm and that you know what (.) Mmm they they prob- its- >their expectations are probably< shaped by being told that there's a responsible medical officer for example or responsible clinician and it sounds like you know the person who can prescribe le::ave or the person who can prescribe medication (.) Erm (.) And once the client has that in their <mind> (.) I think that's also where the challenge is for the psychologist which is (.) "well, I'm not here to prescribe anything"

	resources with discourse processes	
Ideological dilemma Bridging the gap between the person's expectations to be fixed (biomedical) whilst also going alongside the person	IR – person's expectations are shaped by biomedical discourse resources about prescription, permitting leave, and fixing/making better. IR discourse process (bottom-up) of complimentary approach to treatment – not involving prescribing anything SP – manage expectations – is this a challenge? SP - frustration for hcp to manage this limited understanding of expectation ID – biomedical interventions vs talking therapies IR talking therapies as complimentary approach – talking therapies are complimentary to biomedical. Are they seen as less mainstream? Help – accentuated. "help"/influence the person's expectations (from discourse resources) with discourse processes that position psychological therapies as part of the treatment and in line with cop values.	**Cathy line 104:** is the person's expectations to-to <be fixed in some way↓> because they are in a hospital erm (.) I think (.) I- I don't think that people associate hospital settings as being very conducive to having psychological therapy input↑ and I think that itself can be a challenge it's (.) You almost have to (.) Mmm [tut] go alongside the person but also has (.) Be- be in a:: sort of position tha- that isn't really alongside them but (.) But in a way to to inform them that (.) This is the position that I take (2) that it (.) How do you say that it's not about fixing **Cathy line 118 – 128:** I think the challenge is managing that person's expectation (.) What is it that they expect from being (.) In hospital whatever in hospital means for them (.) Err particularly if it's their first couple of times in hospital .hh and they might <not be> and also and/or they're not familiar with what a psychologist does for example (.) Erm and that you know what (.) Mmm they they prob- its- >their expectations are probably< shaped by being told that there's a responsible medical officer for example or responsible clinician and it sounds like you know the person who can prescribe le::ave or the person who can prescribe medication (.) Erm (.) And once the client has that in their <mind> (.) I think that's also where the challenge is for the psychologist which is (.) "well, I'm not here to prescribe anything" (.) The challenge is- is trying to (.) Almost (.) <help them to think about> >you know what< there's another (.) Maybe complimentary approach to
SP – patient disempowering - pt has to comply with biomedical interventions to get what they want. Creates inauthenticity	SP – I am not helping them in the way that they want – to go home! IR – biomedical language becomes the focus for not only staff but the patient. They are given the	**Cathy line 589 – 605:** preoccupied with (.) I can- >in their conversations with me< they become so preoccupied with medication and (.) You know "I- I'm not being helped in the way I would like to" [...] It's like (.) They're being given the impression that that is all that (.) That is needed (.) For their recovery (.) To be (.) For want of a better word successful [...] and that ↑well almost seems to do:: the person out of

	impression that medication is all that is needed for successful recovery. IR – professions that hold the biomedical model tightly = limits the person from developing a sense of their own recovery SP – of the patient, fall in line follow this biomedical advice and you will recover. Disempowering?	justice really I- I don't think it's fair for them to (.) It's like you- you try (.) As healthcare professionals (.) Whatever profession you're in (.) I believe that people (2) should have the information >as much information as they< (.) Can in order to make (.) An informed choice (.) Decision (.) So (.) If (.) That particular profession that holds the biomedical (.) Model very tightly (.) talks in those terms (.) It's it doesn't leave space for (.) Other forms of narrative to develop (.) Within that person↑ or to help them to develop other narratives↑ (.) about their recovery↑ (.) erm (.) And I think that (.) I- I just think that (.) That's quite unfair on the person (.)
Challenging expectations of biomedical setting with personal touch	IR – making it homely – making them a cup of tea IR – pts expectations – intrusive procedures – "jab me"	**Lara line 65 – 68:** so definitely when they first come on the ward the first thing I do is make them a cup of tea [R: right] "let go and have a cup of tea" (.) And they sort of look "well you're the nurse aren't you here to jab me or aren't you here to do this and that"
SP of patients about themselves = "broken" breaking down that sp	IR – pts expectations of self "why am I broken?"	**Lara line 213 – 214:** yeah (.) I think (.) The amount of times that you get people come in (.) The first questions are "why me" "why am I broken"
Bridging judgements **Working on an emotional level** **Compassion**	IR – bridging judgements pts have on self – let family down" shame, Working on emotional level	**Lara line 216 – 220:** and the we have to sort of break that down of- and there will be the stereotypical "well, I've got everything, I have a wife or have a child I have this, why has this happened I feel a let down on my family" this this and this [...] so you have to sort of deal with that (.) on an emotional level
Prioritise the pt over expectations, situation and ward environment	IR – push the expectations/situation/ward environment aside – to prioritise the pts	**Lara line 233 – 238:** but (.) Can we just push that aside and actually the real reason why you're here if you can just concentrate on you (.) [R: yep] all of that other stuff will (.) [R: won't matter] hopefully not matter
Media – discourse resources **ID – bridge expectations**	IR – media understanding - psychosis = admission to hospital/treatment ID – bridging expectations of media and understanding of psychosis from patient's perspective	**Lara line 390 – 395:** if someone had said to me (.) This patient has got a psychosis (.) I probably would have said prior to- (.) To training (.) Well they need to be admitted they the treatment [...] so then it was coming to a new way of looking at it that actually (.) For some people (.) Their psychosis isn't always distressing (.)

ID – bridging expectations of media and understanding of psychosis from patient's perspective/what the pt wants (which may not be "fixing" (biomedical discourse**) bridging person's needs (personable approach) with biomedical expectation.**	IR – treatment is required for the "abnormality" of psychosis IR – but what is that patient's "norm"? Treatment is not what they want or need (potentially) ID – bridging expectations of media and understanding of psychosis from patient's perspective/what the pt wants (which may not be "fixing" (**biomedical discourse**) bridging person's needs (personable approach) with biomedical expectation.	**Lara line 397 – 480:** some people (.) I mean I can think of a patient now that erm (.) He has a psychosis but he finds a comforting and actually whilst he was with us (.) And he was being treated I remember him saying to me once (.) "I'm a little bit lonely" [...] I said "why are you lonely?" "because I don't have the voice as much anymore and I don't have the elated feeling" and he said "I don't know who I am" (.) And I sort of (.) Really struck me that potentially he's not gonna be someone that wants to engage (.) [...] because actually he's been so used (.) To having the- these bouts of psychosis that (.) He's rather (.) The- (.) That person and- with those conditions (.) Then actually- and- so I suppose (.) It's been a bit more (.) What is it that they want (.) What does a patient want (.) Not everyone wants fixing (.)
Biomedical discourse "medication compliance" – discourse resources Power of doctor to prescribe leave and discharge Discourse processes – nurses have more personal info of pt **MDT**	IR - medication compliance = discharge Expectations of the staff and expectations of the patient IR – MDT different members of the team have different perspectives on the pt due to their varying degrees of contact – nurse advises doctor due to their time spent with pt. ID - balancing knowledge with intimacy	**Lara lne 846 – 855:** and be able to say that sort of (2) okay so you've got like a patient who is (.) Maybe on a section 3 and yes they are complying with the medication however they've made it quite clear (.) If they were to be made informal they would be leaving the ward and they wouldn't be medication compliant [...] so the doctor's there about to write the recommendations to come off of the detention and we're saying "well actually no you need to probe them more" [...] about what their intentions are about what their intentions are going to be (.) Once sort of their status changes (.)
MDT	IR – working across teams – good community links (joined up care) knowing the patient IR – am I going to be fixed?	**Lara line 1161 – 1171:** to sort of say right (.) We've got them (.) I always say to a patient when they come (.) "oh when I go am I gonna be fixed?" And I go "no you're only gonna be sort of like 80% 90%" [...] the rest is for you to do when you get home (.) The maintaining your wellness (.) I s'pose that's where the good community links come from (.) Within the MDT team to say right we've got them (.) And for them to go "actually yeah this is the best we've seen them for a long time [...] let's take them and run with it and see what we can get or

		for them to go “actually I've known him be better” [...] so what (.) Can we do to get him (.) Sort of like that- that next step up (.) If you know what I mean
Managing expectations	IR – managing expectation pt and their family	**Lara line 1188 – 1189:** and like I say (.) Managing of expectations of (.) Patients and families of (.) This is what it’s gonna look like when we go home
Good TR enables recovery “recovery” – discourse resource	Good TR – enables recovery, not just nursing them TR can be broken	**Sarah line 23 – 29:** I guess it’s that it has to be very therapeutic to enable recovery (.) Or support and I think (.) Keeping those things in mind makes you want to (.) Build that therapeutic relationship even more because it’s going to be more helpful for that person (.) A good working therapeutic relationship than just (.) Having them their just to nurse them without that relationship you know [...] you’re not (.) You’re caring for them but you’re not necessarily helping them recover and.) Build those relationships again which can often be broken
Hope	IR – like getting to know them & supporting IR - being there for people seeing them get better IR - hope	**Sarah line 42 – 49:** oh erm (.) I just love my job (.) I’m still at that point that I love it erm (.) What I like about inpatients is I really like spending time with the young people my patients (.) And getting to know them and supporting them on a daily basis that is something that I do (.) Really love (.) And I think (.) Although it's a really tricky time for these young people and (.) alot of them it’s their first time in inpatients (.) And some of them are extremely young (.) And I think (.) I just- I just like being there for people and I like- I like seeing them get better (.) And I think (.) Particularly in CAMHS that’s why I like CAMHS so much (.) Is because (2) with young people there is more hope than in adult services↑
Hope	IR - interesting and enjoyable – working with psychosis. You see them get better – hope (line 48)	**Sarah line 477 – 479:** I think (.) I find it extremely interesting and I really enjoy taking care of people with psychosis because generally you see them get better (.) And that (.) As a nurse that’s always what you want to see
Like psychosis – interesting and unusual	Nurses excited to get psychosis admission (CAMHS) IR - nurses and other ward staff – excited to get a psychosis admission.	**Sarah line 481 – 483:** and I think (.) So with regards to other nurses in the team I think (.) I think there’ a general consensus of that I think a lot of people (.) Really enjoyed that we get psychotic patients and a lot of the time when we get referrals and it’s a boy with psychosis we’re like “ah yeah” (.)

Lack of hope – chronic pts Managing expectations	IR – chronic patients – lack of hope – difficult to stomach **Managing expectations (patients)** ID – pt expectation = you're just going to leave (don't care); hcp intentions = wanting to build a relationship IR – difficult to deal with the lack of hope IR – how to cope with this --> establishing friendships – be supportive – managing their expectations IR – navigating heartbreak associated with the lack of hope	**Freya line 44 – 46:** I think one of the things I found most challenging was that I was working from a place of (.) So I work with a lot of chronic- chronic patient so I was (.) I was working for a place of knowing that they were not- not going anywhere (.) So (.) That was difficult to (.) Stomach at the beginning **Freya line 48 – 54:** you know (.) A goal you know (.) Or- or year yeah how do you- where do you take it you know they know they're going to be here for (.) I was just about establishing a friendship↑ (.) A friendship-type relationship↑ where I was (.) Just a support-part of their support system↑ (.) And that was very challenging because (.) It was difficult to manage their expectations because they knew I was just a psychologist who was going to <u>leave</u> eventually **Freya line 57-58**: point so it's- it's (.) Navigating the- (.) The <u>heart break</u> I think that comes with knowing- for someone to know- and
Be more process orientated	Amhs IR – suffering (are they?) Be more process orientated and less recovery focused Seeing them on a human level	**Freya line 425 – 432:** and not thinking of it <u>as</u> suffering because a lot of them [...] aren't suffering so this is- (.) This is my thing where I'm not sure if (.) Like why is it my place to think of the suffering because obviously [...] there's a reason why they're experiencing that so (.) Definitely a process- but I've always had a bit of a process (.) Process oriented take on things but at the same time you are- you are confronted with a family of (.) Of people are heartbroken
Finding middle ground/bridging differences. Being two things at once		
Finding middle ground – person-centred biomedical approach	IR – biomedical narrative can be domineering. However, it doesn't have to be. Biomedical talk does not have to be antagonistic to therapeutic relationship way of working. ID – biomedical vs TR ways of working can be synthesised	**Cathy line 609 – 613:** d-do you th-the biomedical narrative and way of working do you consider it erm (.) <antagonistic↑> to the therapeutic relationship way of working is it is it just different type or what what's [...] my view (.) My personal p-professional view is that I think it it's a different type of narrative (3) I:: think it can be antagonistic (.) Depending on how it's approached↑
Synthesis of TR and biomedical	ID – biomedical vs TR ways of working can be synthesised = biomedical	**Cathy line 620 – 634:** I'm (.) However I am anti- erm way it's delivered but with these particular colleagues that (.) You know that I'm referring to they (.) They've managed to deliver

	interventions can be delivered in a person-centred way without limiting the person's choice/autonomy	it in a way that (.) That allows the person some room (.) To think about (.) Choices for themselves↑ rather than (.) Be offered choices (.) In quote marks choices in quote marks (.) That aren't really true (.) Genuine choice↑
Bridging paradoxes– medication Required, but not always the answer (talking helps)	Patient's expectations vs therapeutic relationship ways of working Biomedical vs relational ways of working SP – some staff "just offer medication" a chemical quash" vs other staff (valerie sp) offer listening "offer ears first" ***Biomedical and media discourse resources about AMHS*** *– e.g.; one flew over the cuckoo's nest - quote "medication time. Medication time!"* IR – but to justify my job as a nurse - not just a "pez machine for diazepam" – can listen and talk too SP – that's not what I'm hired for, that's not what I spent 3 years training for. SP – training and qualification = talking and listening not medication. Medication vs my qualification IR – I'll do it (.) If its needed, and offer my ears once medication has kicked in ***Discourse processes of subject positioning*** *- I am not just a pez machine for*	**Valerie line 116+:** yeah (.) Oh yeah I mean self-harming is still very high (.) There is a (.) From the staff (.) When I was in training sometimes I saw a lot of staff who just (.) Would just medicate (.) Just medicate(.) Just offer medication [...] you know (.) Erm as if that is somehow erm (.) You know a chemical quash [...] you know sort it out whereas what you are not doing is (.) You know if a patient comes up to me an asks for medication they are written up to have (.) It's not my job to say to them prove to me how upset you are (.) You know before I will offer this to you [...] and if- I don't think that's my job (.) But I also do think my job is to be offer medication (.) To someone who is in distress you want to talk to them offer your ears first [...] do you want- do you want someone to talk to- do you- do you actually want to tell me what's going on (.) You know what are you experiencing right now? (.) [...] not to justify my actions as a nurse going to get you medication if that's what you need (.) But to justify my job you know I'm not (.) Just (.) A pez machine for diazepam [R: (laughing] (laughing) that's not- that's not what they hired me for you know (.) That's not what I spent three years training for (.) I'll do it (.) If it's needed (.) I'll do it of course I will and then I will offer my ears once that medication has kicked in (.) no hhh (.) You know I won't make people negotiate with me for it (.) it's their medication (.) But what I won't do is offer that before I offer (.) My qualifications (.) And if they don't want to talk to me and I'm not the nurse that you connected to or feel close to (.) That's totally fine (.) That's that's totally fine (.) I don't take that personally

	diazepam"; "offer my ears"	
Diagnosis is a **discourse resource** – but it limits understanding the person **Discourse process** – getting to know them without knowledge of diagnosis = Less prejudgements = meeting the person = TR	Not reading diagnosis to really get to know person (without diagnosis) ID – diagnosis okay, labels not okay. Diagnosis is important, but labels are unhelpful. IR – nursing an individual	**Lara line 751 – 784:** erm (.) And my regular mentor was put with another gentleman who refused for me to (.) Read erm any of the patient's notes prior to me meeting them↑ [...] erm with a view to (.) Not looking at diagnosis and I do think that's probably one of the (.) The best thing ever heard [...] because the amount of times we get a student and we go "oh go sit in the office and read the notes" of- (.) Yes to a certain extent you need to risk factors (.) And by no means am I going to put anyone at risk but actually (.) Does it matter if you know that patient's diagnosis? (.) Or does it matter that we know (.) How they came to be here in hospital? "-coz we're nursing an individual"
<u>Bridging professional frame and personable touch</u> Flexible More colloquial Special connection More personable A laugh and a joke	IR – special connection (above others) IR – being more colloquial/ banter/little bit of a laugh and joke ID - bridging professional frame and more personable touch How? Being flexible, more colloquial	**Lara line 30 – 36:** and someone might say to you "oh you go and talk to them because you know that they will talk to you" and that's actually quite nice to think that you've got that little bit of banter down maybe you're more colloquial in the way that you talk because you know that's how they respond better be able to "right now come on, what's going on what's all this about this sort of nonsense" and actually they'll "oh yeah I know", sort of having that little bit of a laugh and a joke and they realise that we are only human
Two sorts of nurses University wants you to be & The one you have to be on the wards Professional vs personable	ID – two sorts of nurses – nurse the university wanted you to be (professional), and the nurse you had to be on the wards (more personable) splitting within the nurse. IR - black humour in patients	**Lara line 49 – 52:** yeah (.) I mean I definitely felt when I was training (.) I always used to think that there were sort of two type of nurses (.) There was the type of nurse that the university wanted you to be and then the one that actually you had to be on the ward (.) Which was (.) That sometimes patients included use really black humour
Working with other members of the MDT		
If medication doesn't work call the psychologist		**Cathy line 320:** now, I don't know whether it's because the <majority of the referrals> that I get (.) Erm (.), as a psychologist, <u>tends</u> to be:: people who self-<u>harm</u>↑ (.) People who are:: emotionally distressed or or they kind of act (of it a lot) (.) Erm (.) And therefore the staff team feels "errmm! This is really difficult to manage because medication doesn't work!" and therefore can't be used either

Working with biomedical perspective of psychosis.	IR – the person diagnosed with a psychotic disorder, tend to be treated biomedically, don't often get referrals to psychology. IR - within the MDT – psychosis is treated biomedically, not psychologically? Expectation of the team/job of hospital....getting through the psychiatric gatekeepers (who dictate who would benefit from psychological input)	**Cathy line 344 – 350:** in comparison to:: those who have been diagnosed with a:: some kind of psychotic disorder↓ [...] erm (.) And therefore:: I find that the staff team tends <to then go> predominantly (.) >medication< (.) Erm when that happens (.) Then (.) It's like it's a very very special case (.) If they consider that a referral to psychology could be helpful erm (.) And we don't often get referral like that >which is something we are trying to work on<
MDT Ward staff are gatekeepers of who gets psychological interventions	IR – how referrals are made (and by whom) to psychology – who gatekeeps the patient to get access to psychology - impact on TR	**Cathy line 355 – 357**: the therapeutic relationship co- could be shaped or affected is (.) How people see referrals to psychology (.) Depending on the person's diagnosis or what make the diagnosis is
MDT – different members = different priorities	SP – different members of the team – psychiatrist medication compliance – team working (working within the team with members of different professions holding different priorities SP – a psychologist role is to loosen the grip of a particular narrative **(yes that is exactly the point of this discursive research)** IR – are others (ward staff) aware of the language and its influence? IR – recovery = going home	**Cathy line 579 – 587:** you know it's the different profession (.) Erm (.) From psychology and I (.) And that's what makes me also think about (.) The team working aspect (.) Of this role (2) to help loosen↑ perhaps some of the grip on that particular narrative↑ it- it-s not to say that (.) You know the psychology narrative is all perfect and everybody needs to join in on that it's (.) I'm just not sure whether people are always (.) <aware> (.) Of (.) The language that they use the talk that they use (.) [...] erm (.) When they are talking with people about (.) Recovery when they are talking with people about (.) Going home (.)

Bridging gap between doctor (authority and authority) and nurses (personable and equal relationship)	IR – the doctor holds the authority + nurses build TR = bridge gap between pt and doctor	**Lara line 75 – 77:** and then they will always feel that the doctors in an authority figure because they make decisions regarding some of leave and sections and things like that .) So I suppose our therapeutic relationship allows us to bridge the gap between the patient to doctor
Doctor holds authority Nurses more personable	IR – patients advocate (representative) ID - splitting between doctor and nurse - the doctor holds the authority figure part, and the nurse holds the personable part of the split? Maybe?	**Lara line 79 – 81:** that we've we feel that we can be a really good representative sort of advocate (.) And I have many a patient that will be like don't like the doctor because I feel that they don't listen because I don't use (.) The right words or the right terms
Old-fashioned nurse – discourse resources	MDT – brilliant to capture patient's needs and be able to work with those needs. SP – I am very old-fashioned – respect for the doctor and their word is final.	**Lara line 1094 – 1097:** I mean the MDT (.) Are absolutely brilliant (.) They help so many patients (.) In so many ways that I think if we were one profession alone we wouldn't sort of capture (.) Sort of patient's needs erm (.) And be able to work to meet those needs (.) Me personally I'm still very old-fashioned (.) "good morning doctor" "hello doctor" (.) And their word is final (.)
Psychiatrist – superficial TR	SP – doctor's TR is quite superficial	**Lara 1128 – 1129:** I think that's because a doctor (.) A doctor's therapeutic relationship with a patient is quite superficial
Nurses are there more	IR - nurses are there more and running around looking after the ward	**Sarah line 271 – 274:** yeah (.) I would say that was right I'd say (.) As nurses we are (.) A bit more (.) We are there all the- [...] and were running around looking after the ward
In training learning from placements and other staff	IR - placements and experience – "what each diagnosis actually means" applying knowledge helped learn about experiencing psychosis 'actually" - noting contrast Didn't believe/couldn't make sense of what she learned until she saw it Can't quite understand it until you see it in practice	**Sarah line 374 – 380:** remember doing it but not really (.) It wasn't until I worked and had the experience and saw [...] that I could actually apply that knowledge a bit more↑ (.) So I think (.) Again with nursing they sort of tell you about typical presentations and things like that but I think (.) It's the actual placements and the experience of actually seeing it in practice that helped me (.) To (.) Sort of (2) I don't know (.) Like categorise what- what each presentation- or what each diagnosis actually means **Sarah line 384 – 385**: all these things I think actually seeing it in the person is actually (3) actually helped me grasp that that's (.) What is actually happening **Sarah line 391 – 392**: lives (.) Even on a minute scale so those are the ones (.) People can understand but the things like psychosis or

		maybe even personality disorder (.) Can't quite (.) Understand it until you see it
Mentoring and support of the team helps to cope with destabilising elements of psychosis	IR - working as part of a team and with support and mentoring to work with psychosis – as it can be very destabilising	**Freya line 235 – 243:** it is quite a destabilising experience (.) To just (.) To- to (.) Have a relationship have a therapeutic relationship with someone with psychosis because (.) And there needs to be people around you who have worked with psychosis because like (.) They would get it– they would understand (.) It can't be done in isolation it can't be done (.) You know alone (.) It has to be done as part of a (.) team yeah (.) So it is- it is- (.) It has its own (.) Specific- (.) Special quality of (.) Like erm (.) Instability (.) I guess or I don't know like (.) Throwing you off there's a (.) There's a (.) There is a (.) Special feeling that comes when you work with someone with psychosis
MDT Nursing team, psychology and psychiatry – working together to help the person	Nursing team, psychology and psychiatry – working together to help the person	**Valerie line 813 – 817:**because if I do one thing (.) And psychology and doing another thing (.) And psychiatry are throwing in medications that make it difficult for us to have conversations [...] all three of us need to find a way (.) Professional and to sit together to help this person move forward (.) So a lot of talking
MDT collaboration **The TR as more than just a dyad - working in an MDT** **consistency in treatment** **TR is a chain**	SP – advice seeker SP – respect other professional perspectives in the MDT IR - the therapeutic relationship – actually a chain, not just two people.	**Valerie line 822 – 855:** I know that we've got (.) You know a woman that comes in and thankfully- fi- finally got a psychologist in house but she only works with us (.) Two and a half days a week and then she does another day and a half out in the community [...] in the team and then she got her own practice separate from that and so we get slithers of opportunity (.) So I know the days that that lady is in (.) And I will make sure that I would go and see her on those days (.) I know she is going to make a cup of tea at some point in the day (.) [R & P: (laughing) R: and when you speak to the psychologist do you find that there is more of a focus on (.) Building that therapeutic relationship and you know it's sounds like you can enjoy your you know being able to]. well hopefully I'm helping (.) But I mean if a psychologist hasn't been on our ward in a week and a half a lot can happen in a week and a half (.) and I suppose that if you like I'm trading (.) If I trade information (.) With the psychologist about my- what I've (.) Discussed with the patient it's in the notes but if they don't get a week's worth of notes could be- depends on what's been going on (.) that feels (.) That I'm information sharing as I should be (.) But I'm asking for their professional opinion which gives them a sense that I respect that- where they're coming from and I would like

		their advice as a team so my job is not just a build of relationship with the patient it's to build it with the rest of the staff (.) Because if I don't have a relationship with them how am I going to be able to- you know have a therapeutic relationship maybe I suppose maybe actually to look at it it's actually a chain (.) It's not (.) It's not just between two people it could be between three four or five people