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**Conflict, compromise and collusion:
Dilemmas for psychosocially-oriented practitioners in the mental health system**

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Abstract

The nature and causes of mental health problems are contested. The dominant approach in services views them as ‘illnesses like any other’. The structure, legislative base and practices of mainstream mental health services are largely predicated on this idea, known variously as the medical, illness, disease or diagnostic model. By contrast, psychosocial theories highlight the role of the events and circumstances of peoples’ lives. The tension between these two approaches can lead to challenges and dilemmas for psychosocially oriented practitioners. Clinical psychologists participated in interviews and a focus group about these challenges and how they managed them. A grounded theory was constructed which suggested that their responses took three forms: openly ‘dissenting’ (*conflict*), strategically ‘stepping into’ the medical model (*compromise*), or inadvertently ‘slipping’ into it (colluding). Strategies for managing the challenges included focusing on clients; foregrounding clients’ contexts and understandings; holding the tension between ‘expert’ and ‘not-knowing’ approaches; using ordinary language; forging robust working relationships; being mindful of difference and of constraints on colleagues; recognising one’s power and ability to influence; self-care and work/life balance; taking encouragement from small changes; consolidating a personal philosophy; mutual support and solidarity; drawing on scholarship and finally engaging in activism outside work.

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Introduction

There is considerable debate about the nature and causes of psychosis and other ‘mental health problems’, and therefore about the best way/s to intervene (Cooke, 2017a; Johnstone & Boyle, 2018). The two most widely adopted frameworks are said to be the *medical model* and the *psychosocial model* (BPS, 2007). There have also been attempts to reconcile the two in the form of the ‘*biopsychosocial*’ approach (e.g. Frances, 2014; Murray, 2017).

The Medical Model

Definitions vary of the term ‘medical model’ and of related terms such as illness, disease or diagnostic model. Here the term is used to denote the idea that mental health problems are best understood as ‘illnesses like any other’ (Pescosolido et al., 2010). Aetiology is often explained primarily in terms of an underlying problem with the brain, perhaps a genetic abnormality or chemical imbalance (Read, Mosher & Bentall, 2004). Psychiatrists assign diagnoses by classifying into groups of ‘symptoms’ the person’s observed behaviour and/or their descriptions of their experiences (Johnstone, 2014). Medical interventions (mainly medication) are generally seen as the core treatments, with psychosocial interventions typically viewed as adjuncts (e.g. Craddock et al., 2008).

Despite its dominance, the medical model has been subject to sustained critique (e.g. Bentall, 2010; Cooke & Kinderman, 2018; Moncrieff, 2013). Critics highlight scientific, practical and ethical issues: real-life problems rarely divide up in the ways that the categories suggest; no ‘biomarkers’ (evidence of biological causation) have been found (Insel, 2009); disorders are voted into and out of existence by committees (i.e. the panels determining what is included in the standard manuals), and treatment often proceeds relatively independent of diagnosis (Kamens,

2013). Some authors suggest that the approach can lead to ‘myopia’ with respect to the role of life circumstances (McGowan & Cooke, 2013). Others highlight the social and psychological impact of being labelled ‘mentally ill’ (British Psychological Society [BPS], 2011). Note that these are critiques of the *theory* and its associated practices rather than of the medical or psychiatric *profession*: indeed, some of the most prominent critics have been psychiatrists (e.g. Moncrieff, 2013; Mosher, 1998).

The Psychosocial Model

The psychosocial model has been defined as a framework that removes biology from the position of privilege in favour of a focus on the relational, interpersonal and social contexts of distress (Boyle, 2006). Behaviours and experiences - no matter how bizarre or disturbing - are thought of as understandable and meaningful, if sometimes problematic, responses to events and circumstances (Beresford, Perring, Nettle & Wallcraft, 2016; Tew, 2011). As such it is inevitably challenging to the status quo.

Dominant Models within Conventional Western Mental Health Systems

Despite the attempts at integration outlined above, the medical model arguably remains dominant within most Western mental health systems and is reflected in both their structure - with services delivered from hospitals and clinics – and their legislative base (Kinderman, 2014). For many, physical treatments such as medication or electro-convulsive therapy remain the only ones on offer (Beresford et. al., 2016; Read, Harrop, Geekie & Renton, 2018). A number of reasons have been suggested for the model’s continued dominance including the vested interests at stake, the influence of the pharmaceutical industry and social expectations of ‘a pill for every ill’ (Rogers & Pilgrim, 2014).

Clinical Psychology and the Medical Model

Differences of view about the nature and causes of mental health problems are a source of tension and can be obstacles to multidisciplinary working (BPS, 2007). Whilst some clinical psychologists see little conflict between psychosocial and medical approaches (e.g. Congdon, 2007), there is also a strong tradition of critique and promotion of psychosocial alternatives (see e.g. BPS, 2011).

Senior psychologists have urged their colleagues not to ‘jump ship’ from psychological to medical explanations (Harper, Cromby, Reavey, Cooke & Anderson, 2007) and to resist the pressure to adopt medical discourse and practices (Kinderman, 2014). Psychologists are exhorted to engage in ‘constructive conflict’ with colleagues in order to acknowledge and address theoretical differences (BPS, 2007, p.21) and to offer an authoritative and constructive counter-balance to the medical model.

However, little is known about how clinical psychologists, or indeed other psychosocially oriented practitioners, experience working in a system dominated by the medical model, or what the implications of engaging in ‘constructive conflict’ could be (Sidley, 2015).

Johnstone (1993, 2001) describes feeling silenced when working in a multidisciplinary team, and experiencing isolation and a gradual corrosion of her energy and enthusiasm. Newnes (cited in Newnes, Holmes & Dunn, 2001, p.6) states *“The process is tiring, not least due the energy taken up in defending against feeling disliked and waking in the night overwhelmed with paranoid anxiety...”*

Boyle (2002) suggests that in such circumstances some workers reluctantly start to use medicalised concepts and language. Others (Johnstone, 1993; 2001) search for escape routes, for example moving into management, only working with individual clients, or leaving the mental

health system altogether. Gelsthorpe (1997; 1999; 2007) encourages psychologists to remain engaged in critical debate and to channel uncomfortable feelings into constructive action to improve services.

The extant literature in this area consists largely of personal accounts such as those mentioned above (see also Freeth, 2007; Frost, 2012; Sidley, 2015). There has been little systematic empirical or theoretical examination. Moreover, much of the literature relates to problems working in 'the system' in general rather than to those specifically associated with its guiding ideas. This is perhaps a surprising omission given the centrality of this issue not only for many workers but also for many service users (Beresford et.al., 2016) and is one that the current study aims to address. Clinical psychologists were chosen as an indicative example but the issues are likely to be similar for other psychosocially oriented practitioners.

The main research questions were as follows:

- How do clinical psychologists who are critical of the medical model experience working in teams where it is dominant?
- How do they experience challenging it in their teams?
- What are the associated personal and professional challenges?
- How do they respond to these challenges and what enables them to remain committed to working in the mental health system?

Method

The Canterbury Christ Church University Ethics Committee granted approval for the research.

The study was carried out in accordance with university and BPS (2006) guidelines. Data collection and analysis followed standard Grounded Theory procedures (Charmaz, 2006). This research method aims to generate theory which is 'grounded' in data that has been systematically

collected and analysed. It was chosen here because of its utility in exploring under-theorised areas of human experience (Charmaz, 2006).

Participants and Data Collection

Nineteen UK clinical psychologists took part: nine in individual semi-structured interviews and a further ten in a focus group. Interviewees were recruited via emails circulated within the Psychosis and Complex Mental Health Faculty of the BPS (PCMH) and also to the UK Community Psychology Listserve (<https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=COMMUNITYPSYCHUK>). Inclusion criteria included having worked in a mainstream mental health team for over two years, and defining oneself as critical of the medical model (see Smythe, 2009).

Since participants were drawn from throughout the UK, interviews were conducted by telephone. Table 1 presents details of participants.

- Insert Table 1 -

Interview participants were asked to describe:

- How the medical model manifested in their workplace.
- Challenges and dilemmas to which this gave rise , and
- Any strategies they used to manage these.

A further ten clinical psychologists took part in a focus group, with the aim of triangulating data sources and possibly generating richer data (O'Donoghue & Punch, 2003). Participants in the latter were attendees at a regular PCMH faculty meeting, and therefore a less self-selected group

than the individual interviewees. Members were drawn from across the UK: all worked as clinical psychologists mainstream mental health settings. A questionnaire established that all fitted the criteria.

Focus group participants were presented with passages of text illustrating emerging categories from the interviews. Members were asked to discuss their interpretation of the passages and the extent to which they felt these reflected relevant issues.

Analysis

Grounded Theory requires that categories emerge out of the data rather than reflecting prior researcher assumptions or expectations (Charmaz, 2006). Sampling was continued until theoretical saturation was achieved in relation to the majority of categories, i.e. no new data was emerging that did not fit one or other (Bowen, 2008). The analysis was undertaken primarily by the second author (WS) and followed Charmaz' (2006) guidelines. Emerging themes and codes, together with the developing theory were discussed with the other authors, who also coded part of one transcript independently for comparison purposes. Quality assurance measures followed Yardley's (2000) guidelines and included a bracketing interview (Rolls & Relf, 2006), memos and a research diary as well as the cross-checking of coding between researchers. It is acknowledged that there is always an inevitable element of subjectivity in the analysis: our prior assumptions will have played a role. The authors are ourselves critical of the medical model and have struggled with similar dilemmas to those described by participants: the reader is invited to take this into account in evaluating our interpretation and conclusions.

Epistemological Position

The epistemological position adopted was one of critical realism (Bhaskar, 2013; Charmaz, 2006; Willig, 2016). This stance – consonant with the more general stance of the authors - acknowledges that participant statements are just that – statements - and as such are affected by social processes such as desirability responding. However, unlike its more radical cousin social constructionism, critical realism sees these statements as also containing valuable information about the 'real world' albeit seen through a particular lens. Accordingly, the assumption here is that participant statements do reflect, albeit imperfectly, participants' actual experiences, views, feelings and actions.

Results and Discussion

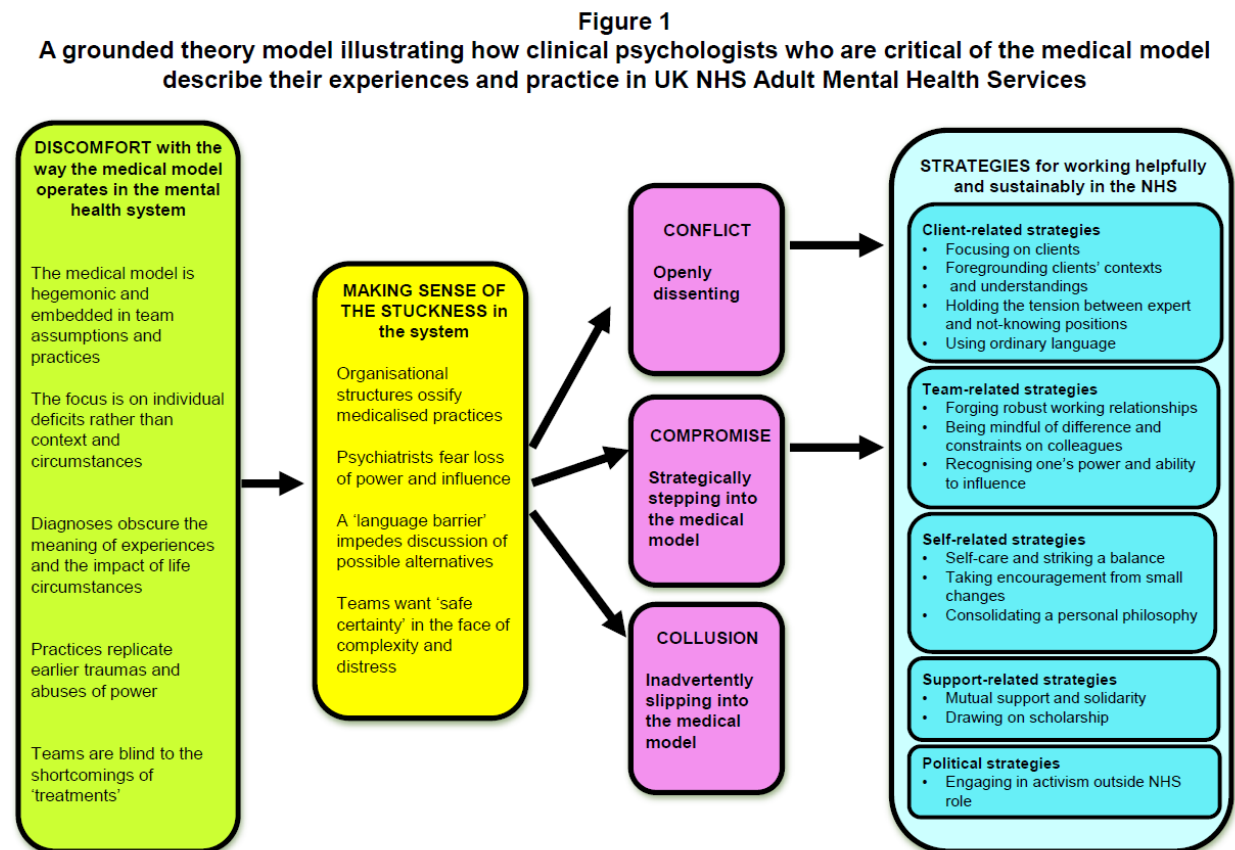
Results and discussion are presented together for brevity and clarity.

Summary

Participants described their **discomfort** at the domination of the mental health system by the medical model, which they saw as hegemonic and embedded in team practices and assumptions. They felt the focus was predominantly on individual deficits rather than on people's context and circumstances, and that diagnoses obscured the impact of life events. They worried that many practices replicate wider power imbalances and earlier traumas and abuses that people have suffered. They felt that teams are often blind to the shortcomings of treatments. Reflecting on the reasons that the system remains 'stuck' in the medical model (**'making sense'**), they felt that organisational structures and practices are hard to change, and a 'language barrier' makes it hard to articulate and share alternatives to medical discourse. They felt that in the face of complexity and extreme distress, teams welcome the (false) 'safe certainty' that the medical model appears to offer. They also suspected that its popularity with psychiatrists was partly related to a fear of losing power and influence.

There were three main ways in which psychologists responded to the hegemony of the medical framework. The first was open dissent (**'conflict'**). The second was strategically 'stepping in' to the model (**'compromise'**). Thirdly, some participants described at times inadvertently slipping into **'colluding'** with the medical model. Finally, participants described the **strategies** that enabled them to remain working in the system in a way that they hoped was helpful. These strategies fell into five categories: *client-related*, *team-related*, *self-related*, *support-related* and *political*. They are described below.

Figure 1 is a visual representation of the grounded theory model that was developed.



Discomfort with the effects of the medical model

Participants expressed frustration at the hegemony of the medical model and the way it was deeply embedded in their teams' thinking and practices.

"In a CMHT the basic assumptions that most people make... kind of fall back on the illness model...you don't have to scratch the surface that much before you get down to that."

(Patrick)

"I've felt frustrations and anger and general disgruntlement with a model that it appears very difficult to avoid in secondary care"

(Hamish)

Teams were also seen as focusing on putative individual deficits rather than on the often very difficult events and circumstances of people's lives. Participants felt that discussions focused on diagnosis and medication, and often failed to consider the person's own views or indeed the possible impact of the diagnosis and treatment itself.

"We had a big discussion this morning about whether someone had delusional disorder or schizophrenia...I was saying ...isn't the point really (laugh) what effect this is having on his life?" (Helen)

Many participants described discomfort with the way diagnostic labels were used within their teams:

"For me, diagnostic labels...are often used pejoratively and dismissively, like, "they are just a bit PD [personality disorder]" Sometimes language can be used to keep people in their place..." (David)

Several participants expressed discomfort at the way that certain practices replicated previous traumas that the person had experienced:

"Some of the practices that we do here... are actually recreating some of the abusive experiences that she had as a child..." (Jennifer)

Some participants were frustrated that their teams sometimes appeared not to notice - or to turn a blind eye to - the possible negative impacts of particular interventions:

“A couple of my clients died while I was there and they had been made to take [name of drug] which ...has potentially fatal side effects. And people just totally failed to see, or didn't want to see, the possible connection.” (Kirsty)

Making sense of how things work in the system

Many participants described feeling discouraged or angry because of pressure to work in a way that conflicted with their values and training:

“You can sometimes end up feeling angry and annoyed with constantly coming up against the medical model when really - that's just not how I think, or how I'm paid to think...”
(David)

This led them to reflect on possible reasons for the system's resistance to change. Some felt that psychiatrists held on to the medical model because they feared losing power and influence should the system become more psychosocially oriented. Many also felt that organisational structures ossified medicalised practices:

“The (Government) Department of Health are asking for targets in terms of diagnosis, there are a lot of external pressures ...to...use that way of thinking about people...” (Jennifer)

Participants felt that another impediment to change was a 'language barrier' (David) that made it hard to articulate possible alternatives in a way that could be heard.

“They can be a bit puzzled... I use terms like 'distress' and 'unusual experiences' rather than mental illness, and people are saying ...no one's going to know what you're talking about if we put that in our professional policy...” (Kirsty)

The idea of a language barrier is consistent with Boyle's (2002) assertion that medicalised discourses have become so dominant that it is hard to find other ways of talking about distress.

Participants felt that one reason that the medical model remains so dominant is that it provides workers with a reassuring sense of certainty. As Coles, Diamond & Keenan (2013) put it: 'A societal understanding may leave (workers) feeling unable to help, whereas biomedical understandings provide an alluringly simple framework and cure' (p. 113). This idea echoes Mason's (1993) concept of 'safe certainty'. Mason suggests that unhelpful interactions can be set up when professionals worry that they ought to have an expert 'fix' for complex problems. Constantly being faced with, and trying to stay attuned to extreme distress also understandably stirs up difficult emotions. Participants felt the medical framework enabled workers to feel they were offering something useful, whilst not requiring emotional involvement with people's distress. It was therefore a comfort.

"If you start to really listen to people's distress and... to what it means, then it's just horrible.(...) It's just so much easier to say, wow, you're just psychotic, take some more pills..."
(Kirsty)

There are also echoes of Menzies-Lyth's (1988) suggestion that for staff involved in difficult healthcare work, working practices and organisational structures can act as a protection against anxiety. This can make practices difficult to change even when they have significant shortcomings.

Finally, the concept of 'emotional labour' may be relevant (see e.g. Edward, Hercelinskyj & Giandinoto, 2017). Workers may have unconsciously been drawing on the medical model 'story'

(i.e. that the mechanism of change is biological rather than being rooted in human relationships) in order to protect themselves from emotional exhaustion.

Having attempted to understand the continuing hold of the medical model, participants were left with the dilemma of how to respond. Responses ranged from open dissent (and sometimes conflict) through various types of compromise, to finding themselves slipping into what felt like collusion. These three types of response will now be addressed in turn.

Conflict: Openly Dissenting

One strategy was simply to offer a dissenting perspective. If offered in a collegial way, this could often be successful:

“Where I am at the moment generally it feels that I am listened to and the alternative is valued”

(Helen)

Others, however said that their attempts were often greeted with ambivalence, ignored or even dismissed:

“It’s isolating, and my God it gets frustrating after a while... you can feel like you’re fighting a losing battle.” (David)

“It (dissenting) was really difficult and it used to just make me feel...like, oh you silly girl, you stepped out of line, why don’t you just keep your head down...” (Kirsty)

Compromise: Strategically ‘Stepping into’ the Medical Model

Some participants adopted a pragmatic approach. When they felt it was in their clients’ best interests, they would sometimes temporarily ‘step into’ the model, either joining in with discussions couched in medical terms, or just keeping quiet.

“It’s about picking battles... I don’t want... it to be a bit of a power battle... that could very well backfire. (Patrick)

“I’m aware of the inconsistency in my positions, but I’m also pragmatic...weighing up the benefits of getting more psychological therapy against the cost of not...challenging the notion of schizophrenia actually existing.” (Helen [on securing extra resources by citing national guidelines predicated on the idea of ‘schizophrenia’])

On a practical level, participants found that it was important to pick one’s battles. As Patrick put it, constantly arguing with other team members “would make professional life just too difficult”. This is consistent with Johnstone’s (2011) view that ‘It is impossible to work as a critical psychologist on, for example, an in-patient ward and not collude to some extent; if you object to every use of psychiatric labelling, your role will be impossible’ (p. 102) . It is also consistent with Court, Cooke & Scrivener’s (2016) finding that clinical psychologists drew strategically on the ‘discourse of power’ associated with diagnosis-driven clinical guidelines in order to achieve ends they believed in.

Colluding: Inadvertently Slipping Into the Medical Model

Compromise could easily become collusion: a number of participants described the sobering experience of finding that they had unintentionally ‘slipped into’ a medicalised way of talking or even thinking.

“I think that it’s quite easy even against your better judgement to get drawn into...using the language and ideas just because it’s there” (Patrick)

This left them feeling guilty and questioning their ability to remain true to their values.

“I think it’s quite easy to get caught up in quite a lot of guilt about it...” (Patrick)

Strategies for Working Helpfully and Sustainably in Medicalised Systems

Finally, the participants described the strategies that enabled them to continue working in the system in a way that they hoped was helpful, and which was also practically and emotionally sustainable. These are outlined next and included *client-related*, *team-related*, *self-related*, *support-related* and *political* strategies.

Client-related strategies included:

Focusing on clients. Participants described how they drew encouragement from their clients’ progress. Some identified more with their clients than with their teams and saw championing their interests as a key priority.

“I don’t feel listened to, so I know what it feels like to be not listened to... I identify with the clients in that way” (Jennifer)

“I see myself working with the system but as an advocate for the client” (Jennifer)

This strategy may have its limitations. Stokes (1994) suggests that idealising the ‘pairing’ between themselves and the client can lead therapists to overestimate the helpfulness of their

interventions. The first author remembers being told by a service user academic ‘the trouble with clinical psychologists is you think you’re the good guys’ (D. Rose, personal communication, 2003). Pilgrim (2005) reminds us that the system is not only about care but also social control, and all staff who work in it are part of that.

Foregrounding clients’ contexts and understandings. A number of participants highlighted the importance of basing interventions on clients’ own understanding of their problems:

“In therapy I take as my starting point the client’s interpretation and meaning...” (Helen)

This is consistent with recent guidance from the BPS Division of Clinical Psychology:

‘Professionals need to work with people’s own ideas about what might have contributed to their problems... professionals should not promote any one view, or insist that any one form of help such as medication or psychological therapy is useful for everyone’. (Cooke 2017a, p.103).

Holding the tension between ‘expert’ and ‘not-knowing’ approaches. Some participants felt it important to adopt a curious, ‘not-knowing’ (Anderson, 2005) approach. However, there were also times when they felt it necessary to assert their professional expertise and authority within their teams. Finding a way of managing the tension between these two stances had been key.

“I work very hard at trying not to be an expert. At times... I need, or people are actually requiring me, to be one.... Getting to grips with this and feeling okay about it has been important.” (Kirsty)

Using ordinary language: Many participants described using clients' own words rather than professional jargon.

"I...just try... my best to describe... what this person is experiencing using the words they use" (Kristy)

This is consistent with Hulme's (1999) suggestion that psychotherapy can often be more usefully conceptualised - and practised - as 'collaborative conversation'. It is also evocative of what service users named as one of the most important attributes for a professional: 'staying human' (Lea, Holtum, Cooke & Riley, 2016). Using everyday language can also be seen as an act of resistance in an environment dominated by a hegemonic medical discourse (Harper, 1995).

Team-related strategies included:

Forging robust working relationships. Participants described the importance of finding allies within their teams and fostering good working relationships. This enabled them to be critical of ideas and practices without fellow team members taking it personally.

"It's about having robust enough relationships with people where you are able to say, look this is my view about this particular thing and it's not actually about my relationship with you..."

(Kristy)

Being mindful of difference and of constraints on colleagues. Many participants tried actively to bear in mind the constraints to which other team members were subjected, the pressures on them, and the nature of their training.

“It’s helpful to hold onto the thought that they’re doing that not because they’re trying to be evil or controlling or punitive: they’re doing it because they believe it’s the right thing to do and how they’ve been trained.” (Kristy)

Recognising one’s power and ability to influence. Participants felt able to use their power for good within the system, for example shaping services or offering training and supervision to colleagues. Parker (1993) found that perceived self-efficacy and power over decision-making was positively related to willingness to engage in ‘reformist dissent’ within the health service.

“I’ve gathered the support of almost the entire organisation ...we (clinical psychologists) don’t just follow protocols, we develop protocols...” (Jennifer)

Self-related strategies included:

Self-care and work/life balance: Many participants said that self-care, outside interests and boundaries between work and home had enabled them to remain productive and engaged. This is perhaps unsurprising and consistent with other accounts of strategies that professionals use to avoid burnout (e.g. Schaufeli, Maslach & Marek, 2017).

“I try not to work overtime and to use my journey home to kind of shake all this out of my head...” (Anthony)

Taking encouragement from small changes. A number of participants took encouragement and motivation from noticing even small positive changes to which they had contributed.

“I try, as I leave work at the end of the day, to identify one small thing that I feel has made a difference to someone’s life or the system.” (Jennifer)

Consolidating a personal philosophy. Some participants stressed the importance of articulating a coherent personal philosophy. This gave them confidence that their alternative views were ‘good enough’ and enabled them to speak out when necessary.

“It’s about how you can be comfortable with your own efforts and find your own way, your place in the system.” (Helen)

Support-related strategies included:

Mutual support and solidarity. Many participants highlighted the importance of being part of a network of professionals with similar views. This finding is in keeping with more general literature on coping, which stresses the importance of solidarity and social networks (Viswesvaran, Sanchez & Fisher, 1999). Having regular supervision with another clinical psychologist was also described as very useful.

“It’s a great source of strength, getting support from within the profession and being part of local and national networks, people who share your views...” (David)

Drawing on scholarship. Many participants drew on academic and service user scholarship. Some described it as helping to ‘crystallise’ their thinking, to remind them that they were not alone in their views, and to justify their position:

“I have a bookshelf stacked full of books... just having them there helps me because I know there are ideas in those books that are supportive of what I’m doing” (Natasha)

“I gave the psychiatrist some papers supporting my view and that felt good, to know I was talking with some authority” (David)

Political strategies.

Engaging in activism outside work. Finally, many participants found that engaging in political activity and campaigning outside work had helped them to reconcile their ambivalence about working within the system.

“I’m quite heavily politically involved...so all the small spats I have locally, I get through that by...getting stuck into bigger spats nationally...” (Anthony)

This is consistent with Gelsthorpe’s (1997) and Cooke’s (2017b) suggestion that clinical psychologists should engage politically to change the system:

“We need to get over our ivory tower preciousness, our worry about what our colleagues will think, and get involved in the public debate... For many of us this is why we belong to the BPS [British Psychological Society] – to join together and make a difference in the world”
(Cooke, 2017b, p.63)

One way of conceptualising such political engagement is that of social justice advocacy. Mallinckrodt, Miles & & Levy (2014) propose a ‘scientist-practitioner-advocate model’ of clinical psychology training which ‘incorporates social justice advocacy, thereby equipping graduates to address social contexts implicated in clients’ suffering instead of only the symptoms’ (p.303).

Implications

The current study has illustrated how in a medicalised system, offering an alternative perspective can be difficult, despite many psychologists seeing this as one of their key roles (BPS, 2007). It has implications not only for clinical psychologists but also for other psychosocially oriented workers.

Participants' accounts suggest that for some teams, medicalisation may be an anchor which enables them to manage the anxiety arising from the complexity and uncertainty of their work, from the distress to which they are exposed daily, and from social expectations that they will eliminate risk (Nalletamby, Marsh and Cooke, forthcoming). This process may help to maintain the hegemony of the medical model despite the problems of the latter. It may also lead to a perverse situation where some workers feel unable to do what they came into the field to do, namely to have helping conversations:

'Staff become passive sentinels guarding and overseeing the delivery of medication cocktails... they become diffident to a source of knowledge beyond their daily grasp. This helplessness extends across their work, limiting their sense of competence when...practical support and enquiry through gentle, respectful curiosity are essential. (Diamond, 2013, p. 321.)

Ironically, in the longer term adherence to a medicalised discourse may help to maintain the 'blame' culture by promulgating the narrative of the 'expert helper' who can avoid adverse outcomes by conscientious application of procedure (cf. 'Zero Suicide'; McGowan 2018). Before change can happen, open discussions will be needed about these issues both at a policy level and within individual teams. Clinical psychologists are well placed to instigate and participate in these. The recent publication of the Power Threat Meaning Framework

(Johnstone & Boyle, 2018) as an alternative to the diagnostic frame may be a useful prompt for such discussions, and the document a useful resource.

Limitations

Due to the sampling strategy the findings may not represent the experiences of all clinical psychologists working in the mental health system. Indeed, a criterion for inclusion was that participants described themselves as critical of the medical model. The issues may also be slightly different for other professionals.

However, generalisability is not the aim of grounded theory: the aim was to explore the experiences and insights of these particular psychologists in order to contribute to theory development. It would be useful to conduct a larger study to elucidate how typical these findings are of clinical psychologists in general or of other psychosocially oriented professionals.

It is nevertheless clear that it is at least possible for practitioners critical of the medical model to find ways of surviving and making a difference within our current, medically dominated mental health system. Despite its limitations we hope that this is a useful account and analysis both of the difficulties and of strategies that can help. We hope that not only psychologists but other workers will find it useful when grappling with their own dilemmas.

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Table 1. Details of Interview Participants

<i>Pseudonym</i>	<i>Work setting</i>	<i>Years qualified</i>
<i>Jennifer</i>	<i>Acute in-patient service</i>	<i>13 years</i>
<i>Anthony</i>	<i>Acute in-patient service</i>	<i>10 years</i>
<i>Natasha</i>	<i>Treatment and recovery service</i>	<i>3 years</i>
<i>Hamish</i>	<i>Early intervention service</i>	<i>9 years</i>
<i>Patrick</i>	<i>Community mental health team</i>	<i>5 years</i>
<i>Klaus</i>	<i>National treatment centre</i>	<i>4 years</i>
<i>Helen</i>	<i>Community mental health team</i>	<i>20 years</i>
<i>Kristy</i>	<i>Recovery service</i>	<i>7 years</i>
<i>David</i>	<i>Crisis team</i>	<i>4 years</i>