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# 'I can see it and I can feel it, but I can't put my finger on it': A Foucauldian discourse analysis of experiences of relating on psychiatric inpatient units

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**Objectives:** Research has shown interpersonal relationships influence experiences of inpatient psychiatric services. This study explored inpatient staff and service users' talk about relating, and consequences on available/limited social actions.

**Design:** A Foucauldian discourse analysis was used to analyse transcribed semi-structured interviews and focus groups with current inpatient staff members and members of a service-user involvement group. **Method.** Two focus groups (service users n = 10; staff n = 6) and five interviews (service users n = 2; staff n = 3) were held, with participants responding to questions regarding the discursive object of 'experiences of relating on inpatient wards'.

**Results:** A dominant 'medical-technical-legal' discourse was seen, alongside a counter discourse of 'ordinary humane relating'. Through the tensions between these discourses emerged a discourse of 'collaborative exploration'.

**Conclusion:** The medical-technical-legal discourse perpetuates notions of mental illness as impenetrable to relating. Staff fear of causing harm and positions of legal accountability generate mistrust which obstructs relating, whilst patients expect to be asked their opinions on their experiences and to be involved in deciding what treatment to accept, and experience frustration and alienation when this is not forthcoming. Ordinary humane relating was described as vital for service users in regaining a sense of self, although not considered enough in itself to promote recovery/wellness. 'Treatment for my problems' was constructed by service users as emerging through the collaborative exploration discourse, where therapeutic relationships can develop, enabling change and a return to safety.

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## Practitioner points

- Discourse analysis of how we talk can help us understand the complexities of being, working, and relating on psychiatric inpatient units.
- Relating as constructed through the medical-technical-legal discourse is seen as the most legitimized but least fulfilling for staff and service users alike.
- Both staff and service users want purposefully therapeutic, collaborative relationships.
- However, the environment does not currently appear to support these ways of relating emerging with legitimacy.
- Some simple steps might be taken to begin the shift towards more fulfilling and therapeutic ways of relating being privileged in psychiatric inpatient environments.

## Introduction

Relating is a central aspect of human experience, with myriad meanings and interpretations. The Oxford English Dictionary (2017) offers three definitions: to make or show a connection between things, to feel sympathy for or identify with another, and to give an account or narration of something. These definitions

themselves connote other nuanced meanings. From a Foucauldian perspective, relating cannot be understood without recognizing enactments of power within the relations being described. Human relationships are seen as multilateral, with each person holding different permitted or restricted social actions, depending on how they are positioned within the relationship at any given point in time (Foucault, 1976). One way of understanding what gives rise to these positions and permitted ways of being is to make reference to social discourses. Discourses are defined as 'sets of statements that construct objects and an array of subject positions' (Parker, 1994, p245), informing ways of being in and understanding the world. An analysis of discourse avoids placing value judgements of 'good' or 'bad' upon constructs of language, providing instead an understanding of how different uses of language produce different effects.

The way power operates within relationships between people enables the potential for experiencing happiness, soothing, and containment, but also pain and anxiety. This is no different when considering relations between 'people in distress' and 'mental health services'. In such circumstances, people seek compassion, care, and reassurance, with the lack of this associated with negative health and social care outcomes (e.g., di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001; Martin, Garske, & Davis, 2000). Most complaints about psychiatric inpatient wards are about the relational aspects of the experience and have been raised as a particular area of need for future research (Rose, Fleishman, & Wykes, 2008).

A literature search on relationships in psychiatric services found a great deal of publications on scientific relationships between medical variables and their associated clinical outcomes; however, little was found in regard to the experience of relationships between the people on the wards. What is published tends to report that psychiatric inpatient wards are experienced as unhelpful, even antitherapeutic (e.g., Holmes, 2002). Service-user satisfaction studies of inpatient psychiatric services found that 82% of 364 respondents reported spending <15 min per day in face-to-face contact with staff, with only 20% feeling they were treated with dignity and respect (Baker, 2000; Mind 2004). Two qualitative studies (Gilbert, Rose, & Slade, 2008; Stenhouse, 2011) reported that nurses were expected by service users to instigate conversations, guide relationships, and be clearly approachable; however, nurses were experienced as too busy to fulfil these expectations. When service users did experience positive interactions with staff, this was named as a time when staff were available to talk and listen in non-judgemental and open ways. Mirroring these experiences, Clarke (2006) describes visiting psychiatric wards in her capacity as a carer. She described interactions with staff as like relating to a 'professional facade', with staff hiding their feelings and being unresponsive to the feelings of others. Clarke also experienced this emotional un-responsiveness as feeling unlistened to and un-related to, leaving her feeling frustrated, dissatisfied, and ultimately having no faith that services had the skills and resources required to help her son.

It is not the case that all experiences of psychiatric wards are negative. In a heuristic exploration of the experience of being both an art therapist and psychiatric inpatient, Woods and Springham (2011) highlight the complexity of interpersonal relationships in such environments. Amongst other constructs, the notion of 'concrete care for concrete minds' was named as particularly important, where Woods' state of mind at that time precluded reflective thinking, and she found containment through engaging in practical tasks alongside nursing staff. This concreteness also intensified the need for transparent, open, and honest relating by staff, allowing the experience of doing these tasks together to become possible.

The quality of these relationships also influences subjective feelings of safety. Findings by Stenhouse (2013) and Gilbert et al. (2008) have shown that where relationships between staff and patients are defined by notions of 'being listened to' and 'nonjudgemental attitudes', patients report subjective feelings of safety from risk from themselves, although they still reported anxiety regarding risk from others. This anxiety regarding risk from others was seen by researchers as a consequence of patients drawing on social discourses of 'mental illness' and 'psychiatric units' to assess risk from other patients. Particularly, the notion that people in psychiatric units are violent and dangerous because they are mentally ill was prevalent.

These reports highlight the unspoken power of relating onwards, and how the quality, presence, and absence of different kinds of relating can mediate the experiences of service users, carers, and staff. This emphasizes the centrality of relationships on psychiatric wards in promoting positive outcomes and avoiding iatrogenic harm. Further, the evidence suggests that a better understanding of the discourses influencing relationships between staff and service users may have an effect on how both inpatient and community services seek to work with service users.

## **Rationale**

This study aims to contribute towards understanding how discourses influence relating on Psychiatric wards. A Foucauldian discourse analysis (FDA) was selected, as it enables analysis of the influences of power in discourses. Three research questions were considered:

1. What discourses are drawn on when individuals talk about their experiences of relating on inpatient wards?
1. How do these discourses influence the availability of social positions that individuals act into?
2. How do these discourses and social positions influence the experience of being on a psychiatric inpatient unit?

## **Methodology**

### **Context**

Participants were recruited from a semi-urban London Borough, with demographics similar to national statistics. Staff were recruited from the borough's psychiatric inpatient unit. Service-user participants were recruited from a local partnership group, offering service users and carers training in research skills and volunteer NHS placements. Two separate focus groups were held, one for service-user participants and another for staff participants.

### **Participants**

Three staff members and two service users were interviewed; nine service users and six staff participated in focus groups. All names used are pseudonyms.

### *Criteria*

Staff must have worked in the psychiatric inpatient unit in a client-facing role for at least 6 months. Service users were current members of the partnership group at the time of research with at least one inpatient admission, ending at least 6 months previously. These criteria were widened for recruitment to focus groups.

### *Service-user participants*

Nine service users participated in this study (Table S1)<sup>1</sup>. Four focus-group participants had not been inpatients, but had conducted research on inpatient wards from a service-user perspective, so their views were of interest and relevance. The analysis of these respondents' contributions was conducted in the same manner as those respondents with lived experience of being an inpatient, as their experience of being onwards was from the position of being a service-user building relationships with people positioned as staff. Although these participants would have different experiences of these relationships, it was felt that limiting their involvement to the focus group only would complement the research without it leading to a bias in the findings. Further, through the analysis, it was seen that these participants' contributions were focused on substantiating the input of people with lived experience of being an inpatient, so they were not introducing new concepts to the analysis. Two focus-group participants also participated in interviews.

### *Ward staff participants*

Eight staff participated in the study (Table S2). Six staff participated in the focus group, and three were interviewed, one of whom was also a focus-group member.

## **Design and epistemology**

The discursive object (Willig, 2008) was 'experiences of relating', with FDA used to analyse the discourses drawn on by participants. FDA is a qualitative methodology situated within a social constructionist framework. 'Discourses' are networks of meaning constructed through language and social actions which construct perceived reality. Several discourses may be drawn on in understanding experiences and may shift over time and context. Additionally, social positioning theory was drawn on to aid understanding of the processes by which available discourses act to limit and expand social positions and

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<sup>1</sup> See supplementary tables at end

associated actions, ultimately influencing a person's subjective experiences of self and other (Harre & Moghaddam, 2003).

### **Interview schedules**

Semi-structured interview schedules (Tables S3 and S4) were designed using interview guidelines (Robson, 2002; Willig, 2008), consultation with an expert in FDA and a service-user group. Questions were designed to be open and to give the opportunity to describe the interpersonal environment as it was experienced.

### **Procedure**

Participants were recruited through attending staff meetings and the service-user group's regular meeting. All interested parties were given information sheets and asked to make contact. Due diligence was given to seeking informed, written consent. Interviews and focus groups were audio-recorded, transcribed, and then analysed using the six-step model of FDA (Table S5) and discursive analysis (Willig, 2008), allowing additional analysis of how discourses are used to legitimize or challenge power positions.

### **Ethical considerations**

Research and development and ethical approval were granted by the relevant NHS bodies. Feedback included that attention should be paid of risk of harm to the researcher and distress to participants and to consider the Mental Capacity Act when seeking consent.

### **Quality assurance checks**

There are four main aspects of qualitative research to be assessed in quality appraisal: credibility, transferability, dependability, and confirmability (Hannes, 2011). Evidence of each of these areas has been scrutinized by external professionals in the field, who felt that each area was sufficiently met.

## **Results**

Three discourses were named in the analysis. The most dominant was the 'medical–technical–legal discourse', alongside a counter discourse of 'ordinary humane relating'. Tensions between these discourses were noted, giving rise to a discourse of 'collaborative exploration'.

### **Medical–Technical–Legal**

All participants' responses to the first question of 'how do people relate with each other on this ward?' positioned people as either 'patients' or 'staff'.

#### *Service-user Interview, Hannah:*

Do you mean how patients interacted, so we're not talking about the staff at all? (L16-17)

#### *Staff Focus Group, Marika:*

Do you mean like with staff and staff, as well as staff and patients? (L6)

This immediately defines people as different, exposing power imbalances in these positions. This need to name positions before the question could be thought about exposes the strength of this discourse and how it has come to structure the common-sense reality of being on a psychiatric ward – only two groups exist, and you must belong to one of them.

From a 'patient' perspective, this discourse legitimized the positioning of 'staff' as people who relate only in a cold, clinical manner. Reasons for admission were defined as discrete symptoms separate from the person, with an expectation that the treatment of these symptoms would be done by an expert giving a clear rationale. The experience of being on the receiving end of this clinical relationship was of a one-way process, with the 'patient' feeling detached and uninvolved. Through this discourse, 'patients' expected 'staff' to have expert knowledge to cut through the 'illness'. Where this expectation was not fulfilled, the 'patient' felt disappointed with their treatment, and spoke of 'staff' acting as uninterested in their personality or views. The 'patient' then positioned the staff as uncaring, unable to understand their experience, and purposefully withholding.

One service-user participant, Mohsen, spoke from the position of having been an inpatient previously, and now working as a health care assistant on a ward. He spoke of the forbidden nature of an authentic relationship in his working role.

*Service-user Focus Group, Mohsen:*

I think with the staff there, it's very plastic. It's very false. There is no relationship . . . any expression of emotions [by staff] is forbidden. If you see, sometimes you do see [staff] going to that length but [service-users] kind of disbelieve it . . . you still think there is something between us, there's a glass wall between us. (L35-39)

This experience was understood as a consequence of being 'a mental health patient', where you are intrinsically untrustworthy.

*Service-user focus group, Emma:*

I mean it's more likely that, say in a normal hospital, that the patients there are more likely [. . .] to be believed. Whereas on mental health [sarcastic tone] whose going to believe them anyway? (L438-440)

From a 'staff' perspective, this discourse constructed relating as a series of objective techniques. 'Rapport-building', a euphemism for 'relating', was constructed as an objective technique enabling intelligence gathering on the severity of illness and to measure the impact of treatment upon it. This positions 'staff' as empiricist scientists, examining and assessing the 'patient' for pathogens, with the power to define what is or is not 'illness', and the associated treatment. 'Patients' then have little power in defining how they understand themselves and their experience.

*Staff interview, Aardash:*

It's my experience, my clinical knowledge on the symptoms, manifestations, the knowledge of the patient's diagnosis, their presentations, their treatment plan, what is in their PRN medication list, and you know your general use of communication on a daily basis, problem solving approach, solution focused techniques, a bit of CBT [. . .] you know your patient, you know who you're working with you know what will work for them, it's tested and tried' (L224-238)

Terminology from psychological practice is used alongside medical terms, reconstructing models of therapy as static tools to be used for a purpose selected by staff, removing the intended development of dynamic collaborative understanding. Research is seen as evidence that the 'tool' selected (e.g., CBT) is certain to be effective, dismissing the subtleties and complexities of the evidence base in favour of technocratic process.

Whilst technique becomes privileged, 'care' becomes subjugated and considered not impactful on extreme states of mind. Overt expressions of distress become constructed as emergencies which are non-responsive to relationships, so technique-driven interventions and medication become the only legitimate responses.

*Staff focus group, Bola:*

The ward is settled now and in the next couple of minutes there might be an emergency and everything, and everyone is running helter-skelter, trying to like, put things together, trying to see that it's de-escalated and all that (L56-58)

From this position, 'staff' cannot legitimately engage in forms of caring expected by 'patients', instead being limited to 'barrier nursing' (Aardash, L207), restraint, and fast-acting sedatives. Interpersonal relating ceases to be considered a legitimate form of interaction.

*Staff interview, Aardash:*

If someone's psychotic for example or manic you can't do one to one talking to calm the patient down, but with a combination of medication, let's say benzodiazepine, then say half an hour later a little bit of chat, it works. (L214-217)

This notion was directly informed by the construct of mental illness as a disease, described through biomedical language reminiscent of a parasitic entity. 'Patients' were divided by 'staff' into their true personality (host) and illness (parasite). The 'illness' was described as though descending upon the person, afflicting them so that they became aggressive and acted in bizarre ways. 'Staff' are compelled to remove the parasite before relating to the real person underneath. 'Illness' is also seen as altering the patient's sense of reality, distorting their appreciation of self and other. Relating' was described as a way of telling the

patient that their personality was separate from the disease entity making them act, think, and feel in symptomatic ways. The finding of a patient's 'true personality' was constructed as a sign of recovery.

*Staff interview, Amy:*

It just gives you an opportunity to see another side of that person you know as I said if people are particularly unwell it takes a while to get to know who that real person is and I suppose it provides an opportunity to see that person's true personality emerge. (L176-178)

'Patients' were also described as rapidly changing from stable to unstable as a result of illness, with no external trigger. This upholds the view that 'illness' alters brain chemistry, so 'patients' do not have control over their behaviour, and responsibility is held by staff instead. Consequently, a medico-legal framework was drawn on, with staff describing their primary function as an expert duty of care, beholden to higher authorities. Staff were fearful of patients making allegations against them, for which they could lose their job.

*Staff focus group, Bola:*

If you work in health care, you don't have a duty of care to others, but first and foremost to yourself. You have to protect yourself, not put yourself at risk. Then you are able to take care of others. [. . .] If you are having a sort of rapport with patients, I think sometimes because you are working with a mental health patient, who, at this point in time you think they are [. . .] level headed, they are settled and everything and the next minute [clicks fingers] something snaps' (L167-169; L172-175)

This was also outlined by Mohsen, in his dual role of patient and staff member.

*Service-user Focus Group, Mohsen:*

On the ward [as staff], you always cover your own back. [. . .] Many times I've been told 'don't get too close'. To me it was a simple human interaction . . . but many times I got told off [. . .] People talked about court cases you know [. . .] totally made up stories. [Staff] thought well, if you trust them [patients], if you invest emotionally, you get payback. (L250-264)

The edges of appropriate relating are defined by these frameworks, and the idea of relating as a one-way process is reinforced. This constrains staff into acting as legally accountable and responsible agents of the state, preventing other forms of relating emerging without dissonance.

### **Ordinary humane relating**

This discourse captures experiences of ordinary care, compassion and concern reminiscent of kinship. This was not contingent on technique, but constructed as a way of being developed through life experience rather than training.

*Staff interview, Amy:*

You know theories whatever that you can sort of draw on, but quite a lot of the time you don't really give it any thought. It's just the natural part of who you are in the day and that's the role, and it becomes almost automatic really. (L339-341)

Valued interactions were mundane and ordinary. Service users described how sharing purposeful activities with staff helped them to understand each other better, improving trust and safety.

*Service-user interview, Pat:*

[laughing] I remember them going into a great big cupboard trying to find me pyjamas and I was saying 'how come she's got pink ones and you've only got green and blue ones left' and she'd go through them all and, you know it's that sort of- tha- that was nice [. . .] I remember she said "oh we're not shopping in Harrods you know!" (L70-73; L273-274)

When this was not available with staff, it was sought between service users instead. This was described as the norm, with a sense that 'the people who are in charge aren't giving us what we need, so we have to rely on each other.'

*Service-user focus group, Pat:*

I feel that you get more support from the other patients than from staff. I think it's the patients

that kind of get you through the experience, sharing what you're going through. (L118-120)

After having referred to the 'glass wall' between staff and patients, Mohsen goes on to say that this led to an acute need to have an emotionally responsive relationship 'amongst ourselves' within the patient group (L43). Alexej described the power dynamics as similar to being put in a child position.

*Service-user focus group, Alexej:*

[staff] are treating the patients like children as well, you know, like a teacher would be quite rude to students in terms of, sort of shouting at them and telling them what to do and then expect the students to be polite back. It sort of, seems to be like either a parent and a child or a teacher-student relationship. They're not treating patients like other adults that deserve a certain amount of respect. (L405-410).

This combination of 'treating patients like children' and 'having to find emotional support amongst ourselves' feels reminiscent of parentalized children, having to learn how to fend for themselves in an emotionally neglectful environment.

Service users spoke about unqualified staff as qualitatively different to their seniors. They were described as relating in an 'ordinary' way, offering to spend time with 'patients', talking, joking, and making them feel as though they mattered through ordinary interactions and simple conversations. Conversely, 'patients' positioned senior staff as automatons, programmed to hide behind clipboards and tick-boxes. To these participants, it seemed that there was something about being a fully trained professional that prevented a satisfying relationship developing.

*Service-user focus group, Pat:*

[Nurses] They're just ticking boxes, doing paperwork. They've got no time for you [. . .]

[Healthcare Assistants] they're the ones that are more human 'cos they've not been programmed yet (L120-121; L483)

From a staff perspective, ordinary moments of relating affected them on a profound and personal level and seen as a way of knowing that you are trusted.

*Staff focus group, Sally:*

it's nice to know that you've connected with somebody, then you can sit down and like have a conversation with them and you know that they'll talk to you and open up to you. (L317-321)

Marika spoke of seeing how life events interact, leaving people in positions of vulnerability. This revelation was a tonic to her inherited stigma around 'mental illness' and exposed the gossamer thread between service user and service provider, leading her to question the need for the power hierarchy she saw in relationships on the ward.

*Staff interview, Marika:*

In the beginning I found it was very shocking because, obviously any other person coming in from the outside, you know like normally if you're just like walking down the road and you see someone who you think is a bit [pause] not very well, then you might want to like, keep out of their way or avoid making eye contact with them. There's no time for that here, so I think it's really helped me to broaden my mind and not to be scared or think they might hurt me. Most of the patients, they don't want to hurt you or be rude, they just want the help. (L29-37).

## **Tensions/Dilemmas**

Tensions were seen between ordinary acts and the environment in which they occur that were sometimes hard to verbalize. The below quote describes this tension as experienced by Pat when reflecting on a staff member's style of relating.

*Service-user interview, Pat:*

[almost shouting] I can see it and I can feel it but I can't—I can't actually put my finger on it at the moment! [normal volume] [. . .] I would class that [way a staff member interacted] as normal but maybe not within those circumstances, 'cos you didn't seem to see it going on with anybody else or, I didn't receive that from any other staff. (L263-269)



This dissonance between act and environment exposed failings in both. Hannah experienced the ordinariness of surface-level relating as missing the point. There was a feeling that there were other kinds of relationship that were needed and expected.

*Service-user interview, Hannah:*

There were people playing pool and, I don't know they were all chatting about X-Factor, and it almost seemed like they were all- it was like a scene from down the pub [. . .] they all just seemed to be able to have these sort of, what appeared to me to be normal conversations and just thinking gosh this is just like, I don't know it just seemed really bizarre to me. (L117-119; L129-131)

The above examples expose the tensions between the experiences of being simultaneously related to through competing discourses. The withdrawal of the ordinary relationship when the medical–technical–legal discourse became re-enacted was experienced by service users' as a loss of their humanity, and responded to through a civil rights discourse. This was used by service users to prove that they are trustworthy and not wasting resources, with their needs just as valid as other vulnerable people. This appears to be a direct response to the de-personalized relational framework felt when relationships were defined through the medical–technical–legal discourse. These concerns appear to relate directly to wider social discourses around what it means to use public services at this point in time.

*Service-user focus group, Pat:*

I find this so hard to accept because, I'm just thinking, if you was on a surgical ward if you were treated like that obvious- I would imagine the staff would get into trouble because they have lack of bedside manner so why should if you're on mental health ward you be treated any differently? (L417-420)

Tensions were also evident in the utterances of staff. Unqualified staff were puzzled by reactions from senior staff when seen relating in ordinary ways.

*Staff interview, Marika:*

I've not been to university, I don't know anything out of the text books. I can only, like, relate or communicate how I know and, I don't know some of the time it might not be like the right way or, you- I don't know, if a patient were to say to me "oh hello gorgeous" or something like that and I say back "oh hello gorgeous", some staff would think that you're too friendly with them but to me, we're all one and we're all normal so why not treat them like that?" (L103-108):

[Managers] tell us to treat the patients as if they're, you know, I don't want to use the word normal [gestures quote marks with fingers] but, you know, healthy minded basically. (L186-188)

The hesitancy and gestured quotation marks around 'normal' suggest that it feels uncomfortable to use, indicating tensions between the demands of a medical model of treatment and of ordinary relating. The tensions above exposed a further discourse of 'collaborative exploration'.

### **Collaborative exploration**

Whilst 'ordinary humane relating' was a valued experience, service users spoke of purposefully therapeutic encounters as the expected, and missing, 'treatment' for their problems. A discourse of 'collaborative exploration' privileges ways of relating that are individually meaningful, connected, and emotionally open, with a purposefully therapeutic aim defined by the service user. Through this discourse, service users positioned themselves and 'staff' as holding more equal power relations, with a mutual respect.

*Service-user interview, Hannah:*

He was very gentle with me, and explained what was going to be happening and why. He was non-judgmental as well. I felt that I'd been- and actually thinking about it when I was on the ward I felt people were looking at you and making an assumption and judging you a bit, you know, but this guy didn't do that. (L233-237)

This discourse privileges ways of relating that allow the service user's whole personhood to emerge inclusive of expressions of emotional pain, rather than seeing distress as an invasive pathology to be treated.

Relating through this discourse promoted an experience of being understood in a way that relieved distress, offering containment and hope.

*Staff interview, Marika:*

[a particular patient] was quite rough and ready, and some of the staff would be a bit stand offish or not as talkative because they're not sure how to take the patient, whereas I went and spoke and was like, oh where are you from, what brings you in here, how come you feel like that and even, just staying in a simple conversation and then after that her mood changed [. . .] I think as well it helped her to not have her guard up on the ward. (L194-199; 225-227)

The notion of a 'proper interaction' was described frequently by service users. This included relating on a personal level, where both parties want to have an impact on each other's internal worlds. Having access to someone who wanted to listen and hear your story enabled the speaker to become visible, allowing their distress to be understood as a reaction to their situation, and was received with gratitude.

*Service-user interview, Hannah:*

I think I was just getting more and more and more anxious and I just felt like some steam been let off and thought oh gosh, [. . .] somebody seemed to understand. (L309-311)

Staff felt achieving this kind of relationship was difficult, as it meant engaging with their own personal experience. Although this was seen as an asset in terms of allowing greater authenticity and empathy, it was also seen as exhausting and unbearable and competes with the notions of 'professional boundaries'.

*Staff Interview, Aardash:*

I don't think we realise ourselves how much pressure, how much stress, how much risk we're exposed to and we take home from here, because we're used to it. But if you took somebody else who hadn't gone through that experience in here, they would think oh my god this is, awful this is, unbearable. [. . .] I have myself many times gone home and feel stressed you know, very tired and emotionally drained. Cases like suicide. You know. It affects you. (L362-369)

## Discussion

The two strongest discourses, 'medical-technical-legal' and 'ordinary humane relating' hold distinct, competing implications for the meanings, functions, and possibilities of relating. Where the medical-technical-legal discourse constructs relating as a technique to extract information from/impart information to a patient regarding their 'illness', the ordinary humane relating discourse privileges constructs of mutual care and kinship. Both are used in an attempt to alleviate suffering; however, the ontological position of the medical-technical-legal discourse fosters doubt as to whether it is possible or safe for 'ill people' to relate in ordinary ways. This leaves little room for ordinary relationships to emerge legitimately. Where staff did discuss relating in ordinary ways, it was with a niggling sense of danger. Barrett (1996) reported similar findings, where nurses described patients as being physically present, but their 'essential self' as absent. Consequently, patients' bodies were regarded as holding dangerous potential, so staff maintained distance until the patient's 'self' returned. This legitimizes the practice of expert staff being trained in specialist techniques to restrain the body and ignore aspects of the person defined as 'illness'. Staff interviewed for this study often divorced these specialist techniques from their epistemological origins. This was most clearly the case with psychological techniques; however, medical terminologies from varying contexts were also named (e.g., barrier nursing, a quarantine procedure). Consequently, staff claim use of evidence-based interventions; however, they have been morphed into top-down applications of technique without consideration of the interpersonal relationship.

Discourses using technical language are a common feature of groups claiming a professional or expert status. The lack of a strong professional identity available for nursing staff may mean they rely on language from psychiatry or psychology to claim power. Crowe (2000) commented on findings that nursing staff often use psychiatric language without critical reflection on the inherent social biases of the diagnostic system. It is interesting to note the similar lack of critical reflection here in regard to the appropriation of psychological terminology. This indicates that psychological and psychiatric hegemonies have become part of the taken-for-granted assumptions influencing nursing practice, with an outcome that is dissatisfying for both staff and

service users. In fact, the privileging of technique-driven interactions over authentic curiosity has left this service user group believing that professional training actually makes staff worse at relating.

The strength of feeling underlying experiences associated with the discourse of ordinary humane relating signalled how important these ordinary relationships are, particularly from the service-user perspective. Relating in this way exposed the humanity of 'patients', and the gossamer thread between service-providers and users. This ordinary kind of relating was not 'treatment', but the basis from which 'treatment' relationships could grow.

The discourse of collaborative exploration has similarities with the core tenets of the Open Dialogue approach. Non-judgemental listening, genuine interest in the service user's experiences, understanding the person's reality by coming alongside them, and the service user controlling their treatment pathway options, as outlined in the discourse of collaborative exploration, are all very reminiscent of Open Dialogue and suggest that this may be a framework that would promote relating through this kind of discourse.

One way of understanding why these two latter discourses are subjugated is to consider how wider social discourses of capitalism and neo-liberalism influence the NHS. Crowe and Carlyle (2003) highlight that the role of public institutions has become to manage throughput and risk. Hamilton and Manias (2006) also highlighted that the role of notes has become to amass evidence of a medical diagnosis and to assist in the organization's business objectives (e.g., evidencing that targets are being met to access funding). Since the introduction of austerity policies in 2010, public services must now prove they provide services at the lowest possible outlay cost to tax payers or face restructuring. This environment promotes 'patients' being seen as commodities to be throughput, with economic units of cost, value, and risks associated with them.

In such an environment, effective 'treatments' become those which are standardized, with minimal variation between 'patients', lowest costs, and predictable outcomes. This legitimizes relationships being defined as 'objective tools', much as Aardash did when describing how he drew on theory to influence his practice. If the desired outcome of 'wellness', as defined on a quantifiable binary scale relating to presence or absence of biomedically defined symptoms, is not adequately evidenced and achieved at a low cost, trusts (and, by extension, staff) are seen as incapable. The achievement of idiosyncratic outcomes collaboratively developed with the service user then becomes defined as a resource intensive cost which is hard to justify.

The UN Human Rights Council (2017) have stated the urgent need for attention to be paid to constructs underpinning the discourse of collaborative exploration. They call for policies to target 'social determinants [of mental health issues] and abandon the predominant medical model that seeks to cure individuals by targeting "disorders"' and to 'address the "power imbalance" rather than "chemical imbalance"'. They go on to call for mental health systems to be restructured away from biomedical models, and towards a psychosocial framework. These recommendations echo the experiences described in this study, further justifying the need to re-focus our attention on how we go about the process of relating in mental health services.

### **Limitations**

These participants' views cannot be seen as representative of all inpatients or staff. Members of this service-user group are, by definition, interested in research, and it is likely that they will have preconceived ideas regarding the values of certain ways of speaking in this context. It is also the case that this group is political in its existence, as its function is to promote re-claiming social power. Thus, individuals in this group may have investments in describing power relationships in certain ways that privilege notions of poor relating by staff.

The participants' positioning of the interviewer also needs to be taken into account. The position of being 'a mental health professional' could be expected to make it harder for notions relating to discourses outside of the most dominant to be spoken, so the apparent strength or weakness of the discourses seen here cannot be taken as a full representation. Further, FDA can only address an analysis of what discourses, positions, and consequences may be present and cannot account on its own for motivational bases for certain individuals taking up specific subject positions.

## Conclusion

This study suggests that discourse analysis offers fruitful ways to understand the social experience of being on inpatient wards. Constructs of relating generated through a medical–technical–legal discourse were dominant, although competing discourses were seen. The complexities of these discourses being enacted in tandem allow anxieties about safety and ‘effective treatment of illness’ to come into conflict with constructs of emotional openness and togetherness. Amongst the dilemmas these differing positions pose, people positioned as ‘staff’ and ‘service user’ still manage at times to come together and offer uniquely meaningful experiences. Some moments were described as particularly memorable, precisely because of their ordinariness in the context of a lack of opportunity for such experiences. Service users requested purposefully therapeutic relating, where talking about psychological and emotional pain could be heard and contained. Staff have awareness of this kind of relating, but are fearful that it may be considered ‘unprofessional’ and does not match their own expectations of their roles. This leaves unanswered questions about what personal/professional skill sets staff need to prevent iatrogenic harm, how the organizational and political environments may influence this, and whether the picture seen in this analysis is representative of other wards around the United Kingdom.

## References

- Baker, S. (2000). *Environmentally friendly? Patients' views of conditions on psychiatric wards*. London, UK: Mind.
- Barrett, R. J. (1996). *The psychiatric team and the social definition of schizophrenia: An anthropological study of person and illness*. Cambridge, UK: Cambridge University Press.
- di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: A systematic review. *The Lancet*, 357, 757–762. [https://doi.org/10.1016/S0140-6736\(00\)04169-6](https://doi.org/10.1016/S0140-6736(00)04169-6)
- Clarke, C. (2006). Relating with professionals. *Journal of Psychiatric and Mental Health Nursing*, 13, 522–526. <https://doi.org/10.1111/j.1365-2850.2006.00974.x>
- Crowe, M. (2000). Psychiatric diagnosis: Some implications for mental health nursing care. *Journal of Advanced Nursing*, 31, 583–589. <https://doi.org/10.1111/j.1365-2648.2006.03691.x>
- Crowe, M., & Carlyle, D. (2003). Deconstructing risk assessment and management in mental health nursing. *Journal of Advanced Nursing*, 43, 19–27. <https://doi.org/10.1046/j.1365-2648.2003.02669.x>
- Foucault, M. (1976). *The history of sexuality volume 1: An introduction*. London, UK: Allen Lane.
- Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of hospital admission in the UK. *BioMed Central Health Services Research*, 8, 92–103. <https://doi.org/10.1186/1472-6963-8-92>
- Hamilton, B., & Manias, E. (2006). ‘She’s manipulative and he’s right off’: A critical analysis of psychiatric nurses’ oral and written language in the acute inpatient setting. *International Journal of Mental Health Nursing*, 15, 84–92. <https://doi.org/10.1111/j.1447-0349.2006.00407.x>
- Hannes, K. (2011). Chapter 4: *Critical appraisal of qualitative research*. In J. Noyes, A. Booth, K. Hannes, K. Harden, A. Harris, J. S. Lewin, L. & C. (Eds), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Cochrane Collaboration Qualitative Methods Group, from <http://cqrmg.cochrane.org/supplementalhandbook-guidance>
- Harre, R., & Moghaddam, F. (2003). *Introduction: The self and others in traditional psychology and in positioning theory*. In R. Harre & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political and cultural contexts*. Westport, CT: Praeger.
- Holmes, J. (2002). Acute wards: Problems and solutions: Creating a psychotherapeutic culture in acute psychiatric wards. *Psychiatric Bulletin*, 26, 383–385. <https://doi.org/10.1192/pb.26.10.383>
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450. <https://doi.org/10.1037/0022-006X.68.3.438>
- MIIND (2004). *Ward Watch: Mind's campaign to improve hospital conditions for mental health patients*. London, UK: Author. Retrieved from [http://socialwelfare.bl.uk/subject-areas/servicesclient-groups/adults-mental-health/mind/144545ward\\_watch\\_report.pdf](http://socialwelfare.bl.uk/subject-areas/servicesclient-groups/adults-mental-health/mind/144545ward_watch_report.pdf)

- Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psychocomplex. *Journal of Community and Applied Social Psychology*, 4, 239–252. <https://doi.org/10.1002/casp.2450040404>
- Robson, C. (2002). *Real world research: A resource for social scientists and practitioner researchers* (2nd ed.). London, UK: Blackwell.
- Rose, D., Fleishman, P., & Wykes, T. (2008). What are mental health service users’ priorities for research in the UK? *Journal of Mental Health*, 17, 520–530. <https://doi.org/10.1080/09638230701878724>
- Stenhouse, R. C. (2011). ‘They said you could come and speak to us’: Patients’ expectations and experiences of help on an acute psychiatric ward. *Journal of Psychiatric and Mental Health Nursing*, 18, 74–80. <https://doi.org/10.1111/j.1365-2850.2010.01645.x>
- Stenhouse, R. C. (2013). ‘Safe enough in here?’ Patients’ expectations and experiences of feeling safe in an acute psychiatric inpatient ward. *Journal of Clinical Nursing*, 22, 3109–3119. <https://doi.org/10.1111/jocn.12111>
- UN Human Rights Council, 2017 *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/35/21
- Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Maidenhead, UK: Open University Press.
- Woods, A., & Springham, N. (2011). On learning from being the in-patient. *International Journal of Art Therapy*, 16, 60–68. <https://doi.org/10.1080/17454832.2011.603697>

## Supplementary Tables

**Table 1.**

*Service-user participant demographics*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Years in contact with MH services</b>	<b>Last inpatient stay</b>	<b>Number of inpatient stays</b>
Peter	64	Male	White British	15	N/A	0
Facilitator	52	Male	White British	N/A	N/A	N/A
Paul	31	Male	White British	15	N/A	0
James	30	Male	Black African	15	N/A	0
Alexej	Missing data	Male	Mixed European	9	N/A	0
Hannah	53	Female	White British	8	2 years ago	2 to 5
Mohsen	51	Male	Asian	10	7 years ago	1
Pat	50	Female	White British	6	1.5 years ago	2 to 5
Emma	48	Female	White British	Missing data	6 years ago	1
Sarah	42	Female	White British	Missing data	4 years ago	2 to 5

**Table 2.**

*Staff Participant Demographics*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Time in NHS</b>	<b>Yrs since training</b>	<b>Job title</b>
Marika	22	Female	White British & Black Caribbean	9 months	N/A	Healthcare Assistant
Sally	24	Female	White British	18 months	N/A	Student Nurse
Eloise	23	Female	White British	6 months	N/A	Student Nurse
Bola	33	Female	Black African	9 months	N/A	Healthcare Assistant
Emily	27	Female	White British & Black Caribbean	3 years	1 year	Nurse
Ibe	32	Male	Black African	5 years	3 years	Nurse
Amy	56	Female	White British	12 years	7 years	Occupational Therapist
Aardash	49	Male	Asian	22 years	22 years	Nurse

**Table 3.**

*Schedules for service-user and staff interviews*

1. Tell me, how do people relate with each other on the ward you are/were on?
  
2. Can you tell me about times you felt you had positive interactions with people on that ward? Felt a 'click' with them?
  
3. Do you feel that these kinds of interactions are supported on that ward? Why?
  
4. If there were more interactions like this, what would it be like? Would it be different to be on that ward? How could that happen?
  
5. If you think about your own experience, is this way of interacting the kind of thing that you've been encouraged to do – 'this' is how to act in such a situation? Why do you think that might be the case? (Staff only: Is that through training, or from wider life experience? Service-users only: How else did you work out how to respond to service-users on an inpatient unit?)

**Table 4.**

*Schedule for service-user and staff focus groups*

1. Tell me, how did you experience people relating with each other at the psychiatric inpatient unit/ward you have experience of?
  
2. Were/are there differences in the way staff talk to service-users, service-users spoke to each other, and staff spoke to each other?
  
3. Has anyone ever felt a kind of 'click' with a staff member/service-user on this ward? As if it's really easy to get along with them? Could you describe what that was like, what impact it had on you, if any? What sorts of things help this to happen, do you think?
  
4. When you were there, did you talk to staff (for staff: did service-users talk to you) about personal difficulties, as well as things relating to medication, leave and diagnosis? How did you feel when that happened? What's it like?
  
5. Did you sometimes chat with staff/service-users when you were walking around the ward? What kind of things did you talk about? If not, can you imagine what it might have been like?



**Table 5.**

*Willig (2008) 6 stage model of Foucauldian Discourse Analysis:*

1. Highlight instances of the discursive object in the transcripts.
2. Highlight constructs of the discursive object, locating them in wider discourses.
3. Examine possible functions of these constructs and how this might relate to other constructs in the surrounding text.
4. What subject positions do constructs offer or limit?
5. Examine what practices are seen as (il)legitimate behaviours or actions as consequences of these positions and constructs.
6. Explore what effects these subject positions have upon the speaker's ways of understanding 'relating'.