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## Relating on psychiatric inpatient units

Section A: Experiences on psychiatric inpatient units: A  
literature review

Word Count: 7,942 (+100 additional words)

Section B: Relating between psychiatric inpatient staff and  
service-users: A Foucauldian Discourse Analysis

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### Summary of the MRP Portfolio

This is an investigation into psychiatric inpatient units in the UK. **Section A** reviews the literature on psychiatric inpatient units, looking at their current and historical contexts, and the role of service-user satisfaction in evaluating what makes a ‘good’ service. This review found that interpersonal relationships between staff and service-users are at the heart of a helpful experience of an inpatient admission; however this is also one of the hardest things to get right in such an environment, with many competing influences.

**Section B** is a qualitative research study conducted with staff from an inpatient psychiatric unit, and service-users from a local participatory research group. A Foucauldian discourse analysis is used to examine what discourses were drawn on when these staff and service-users spoke about relating, what social positions are made available or limited through these discourses, and the consequences of this. Three discourses were noted, those of ‘*medical-technical-legal*’, ‘*ordinary humane relating*’, and ‘*person-centred*’. The *medical-technical-legal* discourse was most dominant, and gave validity to notions of mental illness as impenetrable to relating. Tensions between discourses were evident, exposing how ordinary ways of relating are hardest to achieve under the auspices of a medical-technical-legal discourse, yet they were also more meaningful when they did occur because of this.

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Section A:

Experiences on psychiatric inpatient units:

A literature review

Word Count: 7,942 (+100)



### **Abstract**

This conceptual review explores how National Health Service (NHS) acute psychiatric inpatient wards for working-age adults are experienced by staff and service-users. Psychiatric inpatient wards are a long-standing part of NHS mental health services, and provide psychiatric care for people who are deemed to be at high levels of need and risk. The historically and culturally specific contexts of these services are briefly outlined.

Relevant documentation from government departments is considered, alongside staff and service-user feedback, to evaluate what these wards are like. This reveals relating to be a core component of positive experiences of being on a psychiatric inpatient ward, yet also extremely hard to get right in such an environment. Theories are explored to consider this paradox, and how relating can be used as a means of improving healthcare services.

Available empirical literature on the phenomena of relating between staff and residents in psychiatric inpatient units in the UK is reviewed. Very little research was found, but what was available suggested a complex picture, with achievement of meaningful relating being very unpredictable, and staff grappling with deeply personal dilemmas. Gaps and limitations in these studies are identified, before suggestions are made for possible future directions of research.

**Keywords:** conceptual review, psychiatric inpatient unit, service-user satisfaction, relating.

### **Review Structure and Methodology**

Within a context of negative reports about mental health wards, this literature review considers the experience of being on a psychiatric inpatient unit. It is mainly a conceptual review, also bringing in the latest research in the area. Initially, in order to understand what staff and service-users view as important when considering experiences of wards, a general search regarding psychiatric inpatient services was conducted through consulting user satisfaction publications, book materials, and internet databases. These initial sources were found through searches on all major psychological, social science and medical databases, including Web of Science, ASSIA, Biomed, PsychINFO, Medline, CINAHL and Google Scholar. Grey literature was also sourced through general online search engines such as Google, Duckduckgo, Bing, and Yahoo. The outcomes of these searches were used to examine the wider literature regarding issues of interpersonal relating in inpatient psychiatric units generally, also considering relevant associated theory.

Following this conceptual review, the latest research literature specific to interpersonal relating on acute NHS inpatient wards in the United Kingdom were sourced. Literature included in this review was restricted to items published since 1990, as this is year the NHS and Community Care Act was passed through parliament, significantly changing the structure of mental health services. The final literature search took place in March 2014, using the same major databases as for the conceptual review. Search terms used included: 'inpatient', 'psychiatric', 'interpersonal', 'rapport', 'therapeutic relationship', 'alliance', 'attunement', 'connection', 'relationships' and 'relating'. This revealed 940 records, which reduced to 682 after removing duplicates. Titles and abstracts were reviewed, screening out records which were not research looking at interpersonal experiences on psychiatric

inpatient wards, leaving 324 records remaining. These 324 full-text articles were then reviewed for eligibility under the following criteria:

- Conducted in the UK, on NHS Acute Psychiatric Inpatient wards for working-age adults.
- Conducted since 1990
- ‘Relating’ or similar concepts were the object of research.
- Qualitative or quantitative.

This process left 5 research papers to be reviewed, all of which used qualitative methodologies. A PRISMA flow diagram of this process can be seen in Appendix A.

### **Historical Context**

What we now call ‘psychiatric inpatient services’ have a long and complex history. The earliest known structures built specifically for the care of people we would now describe as suffering from mental health problems were the Persian *Bimaristans* in the early 9<sup>th</sup> Century CE<sup>1</sup> (Rooney, 2013). The first specialist structures for people described as ‘lunatics’ in Europe was in the 13<sup>th</sup> Century CE, including the Priory of St Mary of Bethlehem in London (now called The Bethlem Royal Hospital). These ‘Madhouses’ were custodial institutions rather than a source of care or treatment (Foucault, 1961), and became increasingly common between the 15<sup>th</sup> and 18<sup>th</sup> Centuries CE. They were well known, with apocryphal tales of ‘madness’ resultant from vice and loss of reason being common in popular culture. One example of this is represented in Hogarth’s series of paintings, ‘A Rake’s Progress’ (1733).

The ‘Madhouse’ approach was acted against by a Quaker movement, led by William Tuke who opened ‘the York Retreat’ in 1796, based on ‘humane moral

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<sup>1</sup> ‘Common Era’

treatment'. This held a paternalistic approach to care, with sanity being re-found through self-discipline. This model became increasingly popular in the early to mid 1800s and led to a re-naming of 'Madhouses' to 'Asylums' – places of refuge. Asylums grew in popularity and size, peaking at 154,000 beds in the UK in the 1950s (Warner, 2005).

During the 1950s, criticism of the Asylum approach had taken hold, being described as 'total institutions' (Goffman, 1961), generating dependency and iatrogenic harm. By this time, asylums were bereft of the original notion of refuge, being overcrowded with frequent reports of maltreatment (Fakhoury & Priebe, 2007).

### **What Role do Inpatient Services Hold Now?**

A steady process of 'deinstitutionalisation' has taken place, initially announced in the UK by Enoch Powell in his 'Water Towers Speech' (Powell, 1961). Asylums have been replaced with 'Psychiatric Inpatient Units' aiming to provide short-term care for people in acute psychiatric crises. The inception of the 'NHS and Community Care Act' (1990) altered funding structures and resulted in more short-stay admissions, further altering the function and experience of these places. Currently, there are around 12,500 psychiatric inpatient beds in the UK (Department of Health [DH], 2006), at a cost of £461 per occupied bed per day in 2011-2012 (DH, 2012). Medical psychiatry predominates, with pharmacotherapy as the primary intervention (e.g. Feifel, 2008). Services aim to provide containment of risk, assessments of skills and needs, building of trust, and management of bureaucratic procedures (Bowers et al., 2005).

Psychiatric institutions have always been places of paradox; being viewed as acting to control individuals thought too dangerous or different to remain free members of society, but also providing refuge, a "brick mother" (Rey, 1994), a place

for people who are suffering to find containment and where healing can begin to happen. These dual roles of history continue in modern services, where elements of both control and care are expected (Bentall, 2009). The balance of these roles is continually in flux, with social and political influences serving to instigate changes of focus. Over recent years, with the move to community care, the balance in hospitals has shifted to place greater value on the role of risk management, and less on developing an understanding of or resolution to people's problems (Radcliffe, 2006; Bee et al. 2006; Richards et al., 2005). As more people with more acute needs, posing greater levels of risk to themselves and/or others, are admitted to wards, so staff time is increasingly spent striving to manage these risks and the accompanying bureaucratic paperwork (Breeze & Repper, 1998; Hall, 2004; Bee et al., 2006; Deacon et al., 2006; Bjorkdahl et al., 2010). The current financial and political situation that the NHS is experiencing has brought about a focus on 'better for less', with an ever-increasing push for the most 'efficient' and 'effective' services, using the fewest and most 'cost-effective' resources possible (DH, 2010). This may, however, result in relational, emotional, and psychological elements of care being moved out of focus.

The Francis report (DH, 2013) highlighted that financial control systems were put at the heart of healthcare decisions at Mid-Staffordshire Trust, with relational aspects of care, dignity and respect pushed out of cultural awareness, replaced instead by a tolerance of poor outcomes. The report states:

Patients should be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights (p67). Similarly, the report on findings of abuse and neglect of people with learning

disabilities at the private-sector Winterbourne View Hospital (DH, 2012) revealed a culture which enabled residents to be treated in abusive ways, for example using physical restraint as a tool to punish and shame people. Staff were trained only in the use of restraint and no other de-escalation techniques, and were found to be lacking in ways of understanding residents' actions outside of the notion of 'bad behaviour', which required a response of 'punishment'.

These reports highlight the importance of recognising service-users as people, and responding to their physical, social and emotional needs. The recovery, service-user, and system survivor movements have all stemmed from a perception of a lack of compassion in mental health services (Spandler & Stickley, 2011), highlighting ongoing difficulties in the interpersonal domain between services and the people they wish to help. User feedback needs to be attended to, and the ways services engage with service-users is as important as the interventions offered (Roberts & Boardman, 2014). This serves as a call to mental health services to ensure the same harmful phenomena of Mid-Staffordshire and Winterbourne View are recognised, understood, and wherever possible prevented from re-occurring.

### **Experiences of Being on Psychiatric Inpatient Units**

#### **Staff perspectives.**

Working in hospitals is known to be difficult, and to evoke strong feelings (e.g. Menzies-Lyth, 1960). The impact this has on staff may have far-reaching consequences. Sickness absence rates across the NHS were at 4.24% in 2012-2013, costing £1.55billion; however the figure for mental health services is proportionally higher, with a sickness absence rate in the first quarter of 2013 at 5.07%, although rates for inpatient services specifically were not available (DH, 2013).

In a national investigation of inpatient mental health staff morale

commissioned by the National Institute for Health Research, it was found that 49% of staff working on acute inpatient psychiatric wards were ‘burnt out’ or ‘emotionally exhausted’ according to outcomes on standardised measures (Johnson et al., 2011). The authors proposed that this was due to high levels of demand being placed upon staff, with a low amount of autonomy in meeting these demands and low support from management and colleagues – drawing on the ‘demand-control-support’ model (Karasek, 1979). Totman, Hundt, Wearn, Paul, and Johnson (2011) conducted a thematic analysis of interviews with staff on seven inpatient psychiatric wards across London and the West Midlands. They named four themes as holding relevance for staff morale. Firstly the staff team, particularly staffing levels and good peer relationships, were spoken about as essential elements in maintaining good morale. A recurring theme was of not having enough staff to cover the necessary duties as a standard occurrence, becoming more intense when staff took leave. Management and leadership structures were also cited, with consistency and clear communication named as factors in ‘good leadership’. The notion of ‘having a voice’ was named, as feeling unheard or uninvolved in decision-making processes negatively impacted on morale. One Nursing Assistant commented that “I feel like I’m just here to go through processes and the mechanics of the day ... I don’t feel that I have an opinion that’s really valued or taken into account” (p5). The report also highlights how being with service-users can affect staff wellbeing, particularly when working with very disturbed people on acute wards and Psychiatric Intensive Care Units. This was associated with high levels of perceived risk of violence and aggression, and a seemingly ‘anxious-paranoid’ concern that residents on acute wards were using the system to gain access to social resources that they did not really need. Interestingly, a lack of contact time with residents was cited across all working environments as

damaging job satisfaction.

Increased rates of regular or 'pro re nata' (PRN, meaning 'as required') medication refusal by service-users are associated with unstable staffing profiles, for example high rates of staff turnover, reliance on bank and agency staff, and staff sick-rates (Baker, Bowers, & Owiti, 2008; Bee et al., 2008). Studies in the USA (e.g. Leiter, Harvie, & Frizzell, 1998; Garman, Corrigan, & Morris, 2002) found that user satisfaction was significantly lower when staff reported high levels of emotional exhaustion. There is also evidence that staff wellbeing impacts on patient-outcomes in both physical and mental health settings (Maben et al., 2012; Davenport, 2002).

In a quantitative research study of two hospitals in Australia, Greenslade, and Jimmieson (2011) examined the organisational factors impacting on user satisfaction. Surveys were responded to by 156 nurses and 39 managers from a range of medical, surgical and mental health wards. Findings suggested that where the service climate promoted a sense of motivation in the nursing teams, particularly through managerial support and reward, nursing staff were more likely to give more effort to completing their job roles and more likely to go beyond their basic duties, giving extra to their clients. Interestingly, this was only associated with an increase in satisfaction where service-users felt that this extra effort was directed to those tasks perceived to be congruent to their expectations of the nursing role.

### **Service-User perspectives.**

The white paper 'Equity and Excellence: Liberating the NHS (DH, 2010) emphasised the importance of improving user experiences of care in the NHS. Patient satisfaction is also enshrined in the NHS Constitution (DH, 2009), and since the inception of the Health Act (2009), NHS services have a legal obligation to uphold the Constitution. Following from this, the DH requested that the National Institute for



Health and Clinical Excellence (NICE, 2011) produce a guidance document on service-user satisfaction. Consequently, measures of satisfaction are a central indicator for healthcare-quality across all aspects of the NHS. As such, an increasing number of bodies have started collecting and reporting on service-user satisfaction, with a mixed picture emerging.

Problems with inpatient psychiatric services are a well documented phenomenon. In recent years, psychiatric hospitals have been called un-therapeutic at best, and toxic or anti-therapeutic at worst (Holmes, 2002). The rationale for the development of the National Service Framework for Mental Health (1999) cites a number of significantly problematic findings. For example, one third of inpatients were thought to be better placed elsewhere (Shepherd, Beadmore, Moore, & Muijen, 1997); a four-fold over-representation of patients from Black and Minority Ethnic groups (Koffman, Fulop, Pashley, & Coleman, 1997); patients being placed in secure units with inappropriately high levels of security (Creed, 1997), and increasing reports of sexual assaults and harassment (Appleby, 1999). They also outlined that in a Mental Health Act Commission inspection of 47% of acute adult psychiatric wards in 1996, more than 25% of wards showed no interaction between nurses and residents (Ford, Durcan, Warner, Hardy, & Muijen, 1998).

This situation seemed similar in the early 2000's; institutionalised racism within the NHS was reported, with devastating outcomes (Bennett Report, 2003), and boredom and violence reported as commonplace occurrences (e.g. Duxbury, 2002; Radcliffe & Smith, 2007; Quirk & Lelliott, 2008; Boydell et al., 2010). In a study on user satisfaction with inpatient psychiatric services commissioned by Mind, 57% of respondents said they did not have enough contact with staff, 82% of whom reported less than 15 minutes per day face-to-face contact with a staff member whilst on the

ward (Baker, 2000). Mind conducted a further survey in 2004, responded to by 335 current or recent inpatients. This reported that 53% of respondents felt that their experiences of being on a psychiatric ward did not help their recovery, and a further 31% felt it made their condition worse. Only 20% of respondents felt that they were treated with dignity and respect by staff.

A systematic review of papers regarding service-user and carer views of psychiatric nurses (Bee et al., 2008) exposes several problem areas. Service-users perceived nursing staff as unavailable, finding it very difficult to gain contact with their named nurse and only being able to develop a passing relationship with them. Some studies outlined that service-users attribute these difficulties to nurses' high work-load; however most thought a lack of enthusiasm amongst staff reduced opportunities for contact and promoted a sense of being undeserving of care. The sense of a 'passing relationship' was also associated with organisational reliance on bank and agency staff, and high sickness rates. Service-users expected interactions to attend to different needs than were offered. Firstly, they expected the opportunity to talk through problems, enabling them to express emotion and move towards solutions. There was also a desire for social inclusion, and perhaps a duality of expectation was raised with hope for nurses to be "both ordinary and professional" (p449).

In a phenomenological inquiry, Moyle (2003) analysed interviews with seven current inpatients about their experiences of relating with staff on psychiatric wards in Australia. The interviews revealed a sense of being nurtured and cared for emotionally at admission; however this quickly shifted to a focus on physical needs and ignoring emotions. Participants described feeling that their experiences were being treated as symptoms of the diagnosis of 'depression', rather than personally meaningful expressions of distress. Whilst this was expected of psychiatrists,

participants were disappointed that this relationship also emerged with nursing staff.

There is some evidence that inpatient psychiatric units can be experienced as helpful at least some of the time. The website [www.patientopinion.org.uk](http://www.patientopinion.org.uk), which describes itself as “the UK’s leading independent non-profit feedback website for health services”, revealed the following as examples of service-user feedback on the search term ‘psychiatric ward’:

- Kindness, patience, tolerance
- Expertise
- Getting the care I need
- Warmly welcomed by the words ‘you’ll be Okay with us, you’ll be looked after’
- Communication, not patronising, not routine, a wishing to understand someone’s distress in difficult circumstances
- Dedication of the staff

Some of these concepts are also echoed in the literature. An analysis of Canadian patients’ perspectives of the nurse-patient relationship was conducted by Coatsworth-Puspoky, Forchuk, and Ward-Griffin (2006). A dichotomy of ‘good’ and ‘bad’ relationships was named. ‘Good’ relationships involved an initial interaction with a nurse that promoted a ‘glimmer of hope’ through experiencing the nurse as genuine, caring, friendly, available and being a good listener. This developed through the nurse validating the person as a human being, thus building trust and enabling safe disclosure. This period of ‘exploring’ promoted ‘problem solving’, which constituted the middle phases of the development of the relationship, before the final phase of ‘saying goodbye’ gave service-users a sense of closure. ‘Bad’ relationships were initiated through experiences of the service-user feeling as though nurses were

withholding support and care, and not feeling recognised as a human being. This made their experiences of anxiety, discomfort and frustration increase. These interactions promoted the middle phases of ‘avoidance’ and ‘ignoring’, where patients acted in these ways towards nurses and perceived nurses as acting this way in return. The ending phase of this relationship consisted of self-reflection by service-users, wondering why the nursing relationship had failed for them. They experienced feelings of frustration and were still in need of support, even feeling that the experience had done more harm than good.

The quality of the staff-user relationship also arises as essential to care in general being perceived as helpful. Several studies (e.g. Dearing, 2004; Denhov & Topor, 2011; Eriksen, Sundfor, Karlsson, Raholm, & Arman, 2012; Shattell, McAllister, Hogan, & Thomas, 2006; MacLeod, 2012) have described helpful aspects of these relationships as; care, compassion, patience, empathy, honesty, feeling listened to, understood and important, treated like human beings over diagnostic categories, being held in mind, a calm acceptance of the patient’s story, staff giving something of themselves, equality of power, getting to know/becoming known by staff, and developing a shared understanding of how the patient’s past influences their present.

Although the majority of these reports focus on the relationship between service-users and nurses, it must be recognised that nurses are not the only staff who service-users have face-to-face contact with, and the ways in which other professions interact and relate are also fundamentally important. As McLeod (2012) points out, it takes a hospital-wide commitment to provide the cultures and climates needed for good outcomes and satisfaction rates to emerge.

These reports and audits highlight the importance of the quality of relating

available on wards. Experiences of connection and kindness with staff are key to both a positive experience of the inpatient admission, and a therapeutic outcome. Further, it seems that it is where these experiences are missing that service-user satisfaction and staff morale are at their lowest. It is not the case that positive experiences are based on the absence of harmful factors, but rather that the active presence of valued, social, relationship-based factors is essential. These notions are echoed in the calls for partnership working and no 'recovery-free zones' to become central aspects of mental health services (Care Services Improvement Partnership, 2007). This clearly points to the relevance of the Francis Report's recommendations for psychiatric inpatient services, and suggest that a difficulty in providing good-enough interpersonal care is not a spectre limited to Mid-Staffordshire Hospital; haunting physical and mental health inpatient services alike.

### **Theories of Interpersonal Processes in Inpatient Environments**

The interpersonal processes underlying and guiding interactions between hospital staff, inpatients and their distress are clearly complex. Theoretical considerations on individual, group and social levels have been put forward.

In an empirical study of 500 student nurses and 150 qualified nurses, Menzies-Lyth (1960) outlined how unmanageable anxiety was responded to in the nursing population of a general hospital. She used Kleinian psychodynamic theory to highlight the impacts that defences, used to attempt relief from this anxiety, appeared to have on individual health and organisational functioning. Although the content of these nurses' roles was in caring for patients with physical ailments, the anxieties generated by facing suffering, physical or psychological, and having limited methods by which to aid the removal of this suffering, inevitably arouses strong emotional responses, which are reacted to in a variety of ways.

Menzies-Lyth noted systems that separated nurses and patients, by breaking care down into constituent tasks, taken charge of by different nurses. Patients were depersonalised, being referred to through short-hand, like 'the liver in bed 10', removing from nurses' minds the significance of the individual human. A detachment and denial of feelings was fostered through removing nurses to other wards or hospitals at short notice, and valuing those who did this willingly and without fuss. Decision-making in regard to treatment or welfare of patients generated anxiety through uncertainty of the outcome, so was avoided wherever possible. Rituals were developed to minimise the number of decision-making processes, with precise instructions for each task to be performed. Where a decision had to be made, it was checked, re-checked, ruminated over and checked again with others, preferably shared amongst the team.

Nurses experienced internal conflict regarding the level of responsibility inherent in their role. At times, this responsibility was acted against, and aspects of the personality that did not fit with it were denied, split off and projected onto others. Irresponsible impulses were projected onto more junior staff, and burdensome senses of responsibility and strictness attributed to seniors. Systems were also put in place to protect individuals from this sense of responsibility. Formal structures and roles did not define who was responsible for what, or to whom individuals were responsible. Further, responsibility frequently was delegated upwards, as opposed to the usual downwards delegation. This upheld the aforementioned projective systems, as responsible and competent parts of the self were projected upwards in the hierarchy, then tasks requiring those skills were accepted at higher levels than necessary. Equally, as irresponsible or incapable aspects of self were projected down the hierarchy, it would not be possible to also trust those individuals with delegated tasks.

Finally, it was noted that these systems were extremely avoidant of change. Changes within a social system require changes in relationships as well as structures, and exposing anxieties hitherto concealed, leaving them un-defended against. Menzies-Lyth goes on to state that these systems are actually ineffective at containing anxieties, and generate problems anew. They provide basis for ineffective task-performance, high staff/patient ratios, high staff turnover, lowered patient recovery rates, and did not provide student-nurses with the skills they needed for future employment. These ideas offer a detailed and valuable way of understanding how the pain of suffering can interrupt possibilities for experiences of relating between service-users and staff.

Where Menzies-Lyth considers the ways in which things can go wrong, Ballatt and Campling (2013) propose a model of 'Intelligent Kindness' for understanding how relationships can be supported to work better for all. The model incorporates notions of kindness and kinship as essential, yet lacking, components in the modern health service. They describe a 'virtuous cycle of kindness', outlining processes that connect a basic sense of kinship – a shared sense of belonging, sharing resources, sharing risk and working for the common good – with efficient, effective, high-quality mental and physical health outcomes. They state that where an underlying notion of kinship between 'health professional' and 'service-user' is held, kindness (interpersonal warmth, generosity, sympathy and compassion) is promoted. This kindness in turn directs 'attentiveness', where staff notice, think, feel, learn and understand through their relationships with service-users. This attentiveness enables a sense of attunement, as understood in Attachment Theory, where empathy, warm engagement, responsiveness and sensitive caring are enacted (Bretherton, 1992). From here, trust is built – a two way process, which mediates the development of a

therapeutic alliance which research shows to be an essential element of good healthcare outcomes (e.g. di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). This whole process is thought to reduce experiences of anxiety and defensiveness, both in individuals and in the organisation, which in turn reinforces the conditions required for kindness to emerge.

The construct of ‘kinship’ underpinning this virtuous cycle is associated with that of ‘social capital’ – “the range and quality of positive connections between individuals and the social networks that embody people’s involvement in community life” (Ballatt & Campling, 2013 p.24). Individuals with less social capital have access to fewer social resources and have fewer positive experiences of relating to others. They are more likely to find it harder to trust those in authority, especially when in a vulnerable and dependent position as would be expected when using healthcare services. They are also more likely to have worse healthcare outcomes, and are at higher risk of physical and mental health problems and “ill-being” (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006). Thus, Ballatt and Campling argue, individuals with lower levels of social capital are more likely to find it harder to build a therapeutic alliance with inpatient staff members. It is likely that the people who have been admitted to a psychiatric inpatient unit will have low levels of social capital, making the experience of a kind, attentive, attuned way of relating paradoxically both more important and harder to attain. Linking with attachment theory, research shows that experiences of kind, soothing, affectionate behaviour causes the release of endorphins and oxytocin in the brain, which activates specific and coordinated brain cells to produce a mental state of peaceful contentment and safety (e.g. Carter, 1998). This could be exactly the balm that people admitted to a psychiatric ward most need, and highlights a ‘Catch-22’; that staff are expecting



service-users to make the first move, which service-users are least in a position to do.

This notion of ‘kinship’, with its connotations of connectedness and social cohesion, is regarded with a strong and oscillating sense of ambivalence in contemporary Western societies. It is something that is both valued and feared, as we attempt to find a balance between dependence, independence and interdependence. The notions of sharing risk and working in cooperation for the common good have been re-positioned as old fashioned, in spite of growing evidence of the deleterious effects of social inequality for all people (Wilkinson & Pickett, 2010). Inequality and large power differentials can also be associated with fear. The fear associated with dependence can be understood through the concept of ‘othering’ (e.g. MacCallum, 2002; Johnson, Bottorff et al., 2004), whereby people who we are in some form of dependence relationship with (real or projected) are seen as somehow ‘other’ – distinctly different from ‘kin’, who are a part of “our” group.

To understand this process of “othering”, it is useful to consider theories based on linguistic and social-constructionist principles. ‘Positioning Theory’ (Harre & van Langenhove, 1999), for example, considers dynamic discursive processes in language, embedded in interpersonal relationships, as the core means by which individuals are positioned. These processes (or ‘speech acts’) serve to separate and alter the ways that social identities and personhoods of dependent, or feared to be dependent, people are perceived. The process of ‘positioning’ can be tacit or intentional and each position is associated with rights that are censored as accessible or denied by the individual positioned as holding greater social power, capital and resources. For example, the ways in which the behaviours and expressed thoughts of a person positioned as ‘mental health service-user’ are interpreted by a person positioned as ‘mental health service-provider’ will dictate the method and potential outcomes of the interaction.

The interpretation of speech-acts by the ‘service provider’ holds most power in this instance, and may result in the person positioned as ‘service-user’ disclosing personal information, being requested to engage in a particular intervention or treatment, or having their right to choice in this matter removed from them through state-authorised processes (e.g. Mental Health Act, Community Treatment Orders, Capacity Act). These acts separate the individuals acting as intrinsically different, and as belonging to different social groups, positioning each individual as “other”.

The notions inherent in the ‘virtuous cycle of kindness’ as outlined by Ballatt & Campling (2013) are dependent upon the positions taken and/or granted by ‘service-providers’ and ‘service users’. They argue that ‘service provider’/‘service user’ interactions can assist the ‘service user’ in accessing their own reflexive functioning, and therefore reduce distress, when based on a sense of kinship and kindness. Where both ‘service-user’ and ‘service-provider’ are positioned primarily as ‘a person akin to me’ and secondly as having unique needs and/or skills, these kinds of interaction are possible.

### **Relevant Empirical Research**

These theories and literature suggest a fundamental importance of relationships in inpatient psychiatric care and processes that may underlie possibilities of relating. The next section of this review will consider the most up-to-date research in this area, specific to the UK context. As outlined in the earlier Methodology section, a review process revealed 5 research papers to be examined. These papers will be discussed here by method of analysis.

### **Holistic Analysis of Narratives**

In attempting to answer the research question of “What is it like to be a patient on an acute psychiatric inpatient ward?”, Stenhouse (2011) conducted a holistic

analysis of interviews with 13 patients on acute psychiatric wards in Scotland, using an analytic framework based on Gee's (1991) sociolinguistic theory of narrative structure. Patients commented that they expected staff to come to them and initiate conversations and relationships; however staff expected patients to tell them when they wanted time, which patients discovered after several days almost by accident. Barriers to approaching staff included a loss of confidence, a desire to be independent, and staff seeming too busy to approach. Patients spoke of giving up on building relationships with staff, and instead supported and "counselled" each other, generating a sense of "camaraderie". This was dependent on who was on the ward at the time, whether people shared common interests, clicked, and were able to hold conversations. Alternatively, it could be the case that there was a fear of violence, or just a sense of people being different to the usual crowd that an individual would choose to be with, in which case counsel was harder to find.

This study suggests that whilst ward staff may well be prepared to offer support to their clients, they may not be accessible enough to be useful when needed if they take a passive approach, expecting service-users to come to them. This distinction between expectations may help to understand the reports of patients having insufficient contact with staff on wards (e.g. Ford et al., 1998; Baker, 2000; Mind 2004).

In a further analysis of these interviews, Stenhouse (2013) re-focuses on the concept of 'safety'. She describes how she understood participants' utterances as producing intertwined themes of 'help', 'safety' and 'power'. Participants drew on discourses of 'hospitals as a place of safety and therapy', and 'power in psychiatry' to express these themes. There was an expectation of safety, that hospital would provide safety from self and others, and that staff held a duty to provide this safety. Where not

enough was known about other patients to feel safe, participants used social discourses of ‘violence in mental illness’ to pre-suppose what risks might occur – particularly that people in psychiatric units are violent and dangerous, because they are mentally ill. Thus, discourses defined the parameters of relating with both staff and service-users, placing relationships as a central feature of developing a sense of safety on psychiatric wards.

Stenhouse does acknowledge that these results are not transferable outside of this small cohort; however outlines the value of exposing a deep, contextualised understanding of experience which may encourage readers to be sensitive to similar experiences of others. Methodologically, rigour was evidenced in the transcribing and checking of content, and the inclusion of a second interview examining the accuracy and any omissions from the transcripts. They were analysed in a manner which seemed to fit the theoretical underpinnings; however no inter-rater reliability was included. On a note of cultural difference, Stenhouse discusses the relevance of safety in the context of patients sharing sleep dormitories. This is not a feature of psychiatric inpatient services in England, suggesting some significant differences in service structure and organisation even within the UK.

### **Heuristic Analysis**

Woods and Springham (2011) conducted a heuristic analysis of Woods’ experiences of holding the dual role of being a mental health professional and service-user. The focus of the study was on Woods’ experiences of being an inpatient, and used a heuristic methodology to explore how those experiences affected her own experience of being a service-provider in the role of art therapist. This was addressed by asking the central question ‘what have I learned from being the patient that I can use in my practice as an art therapist?’. Six themes emerged; ‘concrete minds’,

‘concrete care for concrete minds’, ‘the waiting art therapist’, ‘the waiting art materials’, ‘genuinely seeking to understand’, and ‘hope’. Relating was either implicitly or explicitly relevant to all of these themes. The theme of ‘concrete minds’ describes how the reflective ‘as-if’ function of thinking had been lost at the time of admission, generating persistent feelings of agitation, fear and distress. This concrete state of mind was understood to emphasise a need for and aversion to human attachment, to both self and other. This experience needed to be contained through ‘concrete care’, as provided by ward staff. The pragmatic, basic level of needs being met on the ward was experienced as enough, with any higher expectations felt to be intrusive. The fact of nursing staff continuing to go about their routines was, for Woods, reassuring and grounding, acting as a reminder that ‘life goes on’. Interestingly, the presence of an art therapist on the ward was experienced as demanding, and provoked a fear of not being strong enough to engage in the kind of relating expected in such an encounter. Springham reflects on how relating to service-users with a therapeutic purpose, either personally or through the presence or absence of objects related to therapy, may be experienced as too probing and threatening when a person is feeling fragile.

The importance of relating was specifically named in the theme of ‘genuinely seeking to understand’. Meaningful relating was experienced when staff were able to work from a genuine human position, making Woods feel listened to and understood. These conversations had no deeper therapeutic aims, and were not led from an intrusive position of information gathering by staff; rather, staff allowed Woods to lead the conversation, giving her space to take the conversation in whatever direction she wanted. In regard to the theme of ‘hope’, Woods referenced the relationships with other inpatients, particularly seeing people become less distressed, giving her hope for

herself. It is taken from this that a stance of relating to patients as ‘fellow humans in distress’ is more effective than taking a highly professionalised stance when attempting to build relationships or therapeutic alliance. This suggests that, from Woods’ experience, the specialist or technical aspects of a mental health professional attempting to engage a patient in a therapeutic endeavour can be experienced as intrusive, frightening, and paradoxically can make it more difficult to engage. Similar to the virtuous cycle of Intelligent Kindness outlined by Ballatt & Campling (2013), an approach of genuine human relating was experienced as the groundwork from which a working alliance could emerge, itself forming a basis for future therapeutic work.

As this is a case-study, these themes are limited to Woods’ experience, and are not transferable/generalisable to others. As the authors acknowledge, it is possible that Woods’ experiences of hesitancy with the art therapist may be due to a wish to protect her relationship with art therapy from contamination with the devastating feelings she was experiencing at that time. An account of therapeutic endeavours with other professionals, perhaps psychologists, psychiatrists or occupational therapists, would have provided an interesting and valuable comparison.

### **Thematic Analysis**

Gilbert, Rose and Slade (2008) published a user led study into the importance of relationships in mental health care. Nineteen service-users participated in total, 10 in a focus group and a further 9 individual interviews, and a thematic analysis was conducted on the data. Interviews opened with the question “tell me about your experiences of being an inpatient”. An iterative analysis of the data led to the identification of eight themes, five specifically linked with relationships. It was noted by the authors that where participants described their experiences of inpatient

admission, they did so within the context of people they had met – the relationships they had formed defined the majority of the experience of being an inpatient. The themes linking with relationships were; ‘the role of communication’, ‘coercion’, ‘safety’, ‘trust’ and ‘culture and race’. Of these, communication was the largest theme, and included categories of understanding, talking and listening. As in Stenhouse (2011), the notions of approachability of staff and how office work can act to remove staff from being available were raised – seemingly akin to the processes outlined by Menzies-Lyth (1960). Some experienced this as a purposeful act, believing staff tried to stay away from service-users as much as possible. Where people felt listened to, as in Woods and Springham (2011), the idea of ‘being human’ was given to describe meaningful ways of interacting, and had a resultant effect of feeling respected. These positive experiences of communication allowed a person to feel supported and cared for. Negative references to communication between staff and patients were plentiful and were associated with coercive communication. Coercive interactions were understood as a means of threatening patients into behaving in certain ways or accepting unwanted ‘treatments’, adding an element of traumatic fear to the relationship. Perceived coercion, or knowledge of threat, was associated with feelings of a lack of safety, which was in turn associated with aggression, fear and mis-trust. It is noticeable that the themes raised here are in regard to the emotional environment of the psychiatric hospital and not the physical environment, and these emotional aspects occur within the realm of relationships. The authors go on to argue that relationships are of central importance to the experience of being in hospital, and also for therapeutic change to occur. Again seeming to echo the work of Ballatt and Campling (2013), without positive experiences of relating on the ward feelings of trust and safety were much harder to develop.

The authors recognise the value of this research being user-led, and note that this may have allowed a different voice to be heard and different data to emerge when compared to other research on the experience of being an inpatient. This study was part of a larger study into residential alternatives to inpatient psychiatric care, and the authors advertised the study through resource centres across London and a service-user magazine. Considering the number of people that could be reached through these means, it seems surprising that only 19 were recruited. Perhaps richer data could have been gathered with a greater sample size that may have contributed further to this understanding of relationships on inpatient wards. Interestingly, the authors report a mix of ethnicities. This study is the only one of the five reviewed here that considered any role of race, culture or ethnicity of service-users as contributing factors in relationships.

### **Ethnography**

In a year-long ethnographic study of three psychiatric inpatient units in central England, Bray (1999) examined under what circumstances professional closeness between nurses and service-users occurred, how the meaning of this professional closeness was constructed, and what made it beneficial. Bray used semi-structured interviews, activity and participant observation, and informal discussion to gather data. The use of interview and observation combined aimed to increase the validity of the research, as this allows a way of exploring the participants' perspectives with least imposition of the researcher's own assumptions. The combination also avoids reliance on the participants' spoken accounts of what they believe they do, so observations serve to triangulate this spoken information.

Bray named three themes of 'working closely with mentally disturbed individuals', 'maintaining distance' and 'congruent care'. The theme of working



closely with mentally disturbed individuals exposed dilemmas of feeling emotionally close to patients, being personally affected by and empathising with their pain, fears and anxieties; yet also trying to restrict the relationship to a professional level. Where staff felt a closeness to patients, this was experienced as painful to have, and also painful to lose. Where nursing staff were able to describe times when they disliked a patient, staff spoke about feeling angry with patients who acted abusively towards them, but also understanding why they might act in those ways. Feelings of frustration, anger and impotence were named, particularly where relationships could not be built, treatment was not effective, or a patient committed suicide. Some nurses went on to talk about these feelings as “we end up feeling what [the patient] feels” (p. 301), which was understood by Bray as counter-transference; however nursing staff did not use this, nor any other, theoretical term to explain the phenomena, and these experiences were not discussed with other staff and so did not overtly influence ward practice.

The theme of ‘maintaining distance’ was strongly associated by Bray to the defences against anxiety outlined by Menzies-Lyth (1960), mentioned earlier in this paper. The most notable distancing technique outlined by Bray was that of ‘Close Observations’, where one nurse or health-care assistant is placed on duty to deliver care and surveillance to one patient over a set period of time. Whilst taking on this role, staff disengaged from the patient and made themselves unavailable, either by sitting outside the room the patient was in or by reading a book or magazine. Other relational activities, such as community groups, were then cancelled because staff were too busy with the observations to facilitate them, thus serving to legitimise distance from all patients.

The theme of ‘congruent care’ was defined as where nurses relate towards

patients in a way that they feel to be right, neither being confused by organisational requirements nor by non-specific counselling; however nurses expressed a dissonance here, that the way they intuitively wanted to care for patients was feared to be unacceptable to the institution and unsupported by known theory. This 'intuitive care' was described as including ideas of being with clients, developing relationships, and generating trust. Where this was possible, a sense of camaraderie between staff and patients developed, with pride in a co-operative achievement. Whilst this was felt to be a time where nurses were at their most therapeutic, it was also thought to not be an acceptable enough level of involvement to be called therapeutic, and was in fact referenced as "frivolous" (p 303).

Reasons cited for the presence of these themes included the exhausting nature of being attentive to others' needs for long periods of time, the patient's diagnosis causing them to give negative feedback to the nurse, and the notion of vicarious traumatisation (Crothers, 1995); so being an emotionally available staff member can expose you to dangerous and painful feelings.

This study provides an in-depth account of the experiences of staff in their attempts to relate with patients; however it is limited by focussing only on nursing staff, and does not give accounts of any other professionals involved in the running of a psychiatric ward. Also, there would be value in the exploration of the descriptions of dissonance and devaluing of intuitive care, and where the notion of 'frivolous' versus appropriate care may come from.

### **Summary and Future Research**

Very little empirical data were available for review in this paper. One possible reason for this is that 'relating' may not be explicitly stated in abstracts or research questions, so further relevant studies may have been conducted, but missed by the

searching process employed here. This highlights the current taken-for-granted position of relating, as it is not often named as a research aim or finding in its own right.

One common theme across the empirical papers was of a clash of worlds; service-users seem to come to psychiatric inpatient units expecting a relational intervention and someone to talk to about their problems; however nurses fear this kind of relating is inappropriate in a service that values medical treatment, and does not offer ways to verbalise or support nurses' expression of the impact of their work on them. When these worlds collide, it seems that neither party understands the other and both feel alienated. Research is needed to understand what effects this can have on staff and service-users, and how these ways of being might be altered to provide better experiences. As Menzies-Lyth (1960) has suggested, social systems do seem to be used in psychiatric inpatient units as a means of defending individuals against the anxieties raised through caring for vulnerable others; however this in itself does not explain the experiences of nurses where they have a desire to care but do not feel able to within the limitations of the institutions in which they work. It seems that staff are aware of the problems, but somehow it seems impossible to instigate or enact change.

Considering that 54 years have passed since Menzies-Lyth's study, it seems remarkable that these difficulties seem to be as relevant and disruptive now as they were then. None of the above research sought to explore possible origins of the values or positions made available to staff on inpatient wards, which ultimately set the scene for limiting or encouraging certain ways of relating. The role of professional training was not considered, and the vast majority of analysis was keenly focussed on how nursing staff relate to service-users, with little or no research on other professions who also work on these wards. The role of power then comes to light, yet throughout the

research above this concept has not been examined.

With the exception of the Gilbert, Rose, and Slade paper, all of the research was designed by and for staff, producing a potential bias in the research. Despite the recent emphasis on patient involvement in mental health services and research from the DH and NICE, service-users' priorities or preferences regarding the research agenda are relatively unknown. One study looking at just this topic by Rose, Fleischman and Wykes (2008) found that service-users placed most interest on research that was social and psychological, rather than biomedical, in its focus. When asked what research environment they felt was most important in considering the effectiveness of services, hospital wards were most frequently cited. Interestingly, there was a split in the sample, with some wanting research to be conducted on how to improve ward environments, and others seeing them as inherently unsafe and failing to meet needs, with a wish for alternative services to be investigated rather than adapting the current way of doing things. This would give a rationale for research to be conducted into alternative approaches services could take for working with people in acute crisis, expanding the evidence-base to enable greater patient choice in preferred treatments.

### **Conclusion**

This review has considered the conceptual and empirical literature on the phenomena of relating on acute psychiatric inpatient units in the UK. Little empirical evidence exists; however what there is supports the calls from user feedback for compassionate, caring, open, and emotionally responsive relating from staff. It is not clear from the research how this can best happen, but some obstacles have been named in terms of having ward cultures that devalue non-technical ways of interacting, staff not feeling supported in exploring their emotional responses to

patients, and the potential for discourses of patients as ‘dangerous and violent’ to go un-challenged and form a basis of interactions. A possible framework for moving forwards is offered by the Intelligent Kindness model proposed by Ballat and Campling (2013), and through an understanding of the social defences that are employed by organisations within hospital environments as outlined by Menzies-Lyth (1960). As highlighted by service-user research priorities, the Francis report and the findings from Winterbourne View, the importance of the focus of care being on patient experience needs to be held, and the research landscape does not currently meet this expectation.

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Section B:

Relating between psychiatric inpatient staff and  
Service-Users: A Foucauldian Discourse Analysis

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## Abstract

### Objectives

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

### Design

A Foucauldian discourse analysis was used to analyse transcripts from semi-structured interviews and focus groups with current inpatient staff members and service-users with prior experience of being a psychiatric inpatient.

### Methods

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, with two counter-discourses of '*ordinary humane relating*', and '*person-centred*'. A '*civil rights*' discourse was drawn on by service-users in the tensions between discourses.

### Conclusion

The medical-technical-legal discourse perpetuates notions of mental illness as impenetrable to relating. Fear of causing harm and staff positions of legal accountability generate mistrust, obstructing relating. Ordinary humane relating was vital for service-users in regaining a sense of self. Through ordinary humane relating, a therapeutic relationship could develop, as constructed through a person-centred discourse.

**Keywords:** *relating, inpatient services, staff, service-users, discourses*

### **Introduction**

Relating is a central aspect of human experience, and is at the core of our social and emotional worlds. It can bring psychological soothing, containment, pain and discomfort (Bowlby, 1988). Where humans experience distress and pain, the need for an external other to provide compassion, care and reassurance becomes increasingly acute. Where these actions are performed by medical healthcare workers, they are categorised as elements of ‘good bedside manner’, and associated with improved physical health outcomes (e.g. di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). These concepts are also core to the notion of ‘therapeutic relationship’ in psychotherapy literature, which again is associated with more positive therapy outcomes (e.g. Martin, Garske, & Davis, 2000). The quality of relationships available on inpatient psychiatric units was raised in an article on service-user research priorities (Rose, Fleishman, & Wykes, 2008) as a particular area of need for future research.

Literature on the experience of being a psychiatric inpatient is frequently based on service-user feedback and audits conducted by NHS Trusts, third-sector organisations and patient groups. Findings have shown that psychiatric inpatient wards are frequently experienced as unhelpful, and even anti-therapeutic (Holmes, 2002). Mind (2000; 2004), studying user satisfaction with inpatient psychiatric services, reported 82% of 364 respondents spent less than 15 minutes per day in face-to-face contact with staff, with only 20% feeling that they were treated with dignity and respect. Ford, Durken, Warner, Hardy, and Muijen (1998) reported a Mental Health Act Commission inspection of 47% of acute adult psychiatric wards in England, where more than 25% showed no interaction between nurses and patients. Two recent studies (Stenhouse, 2011; Gilbert, Rose, & Slade, 2008) report that

patients expect nurses to instigate conversations and guide relationships, or to be clearly approachable; however nurses seem too busy to interact meaningfully. When describing positive interactions, patients remembered experiences based on experiencing staff as available to talk to and being listened to in a non-judgemental, non-patronising, and open way. Where these interactions were not available with staff, people reported seeking peer support to fill this gap.

In disclosing her experiences as a carer, Clarke (2006) describes being a visitor to inpatient wards. Interactions with staff were described as like relating to a “professional façade”, where staff hide their feelings and are un-responsive to the feelings of others. This emotional un-responsiveness is described as leaving Clarke feeling un-listened to, and un-related to.

Relationships on wards aren't always like this. In a heuristic exploration of the dual experience of being an art therapist and psychiatric inpatient (Woods & Springham, 2011), several key components to a positive relationship were highlighted. This included the notion of ‘concrete care for concrete minds’, where a patient’s state of mind precluded reflective thinking, finding containment through the experience of nurses achieving practical tasks. This concreteness was also described as intensifying the need for transparent, open and honest relating by staff; yet this way of being seemed to be somehow incompatible with the professional stance taken by many staff on the ward. Holtum, Lea, and Cooke (in preparation), in discussing results of a thematic analysis of 36 participants’ comments, outline the role of management in providing inspirational leadership, influencing ward culture and enabling staff to “treat everyone as humans”. They also noted that staffing and resource levels need to be high enough and consistent enough to enable staff to engage with patients on a personal level.

In examining the notion of safety on acute wards, Stenhouse (2013) conducted a holistic analysis of patients' experiences in a Scottish hospital, highlighting the discourses drawn on in making sense of these experiences. Staff were spoken of as supporting patients to feel safe from risk from themselves, but unhelpful in containing their anxiety regarding risk from others. Where patients did not know enough about other residents to feel safe, they were understood as relying on social discourses of 'mental illness' and 'psychiatric units' to pre-suppose what risks might occur – particularly that people in psychiatric units are violent and dangerous, because they are mentally ill. Gilbert, Rose, and Slade (2008) also reported on safety on wards. Here, feeling safe was mediated by the quality of relationships between patients and staff: If relationships included feeling listened to in open, non-judgemental ways, then patients were more likely to report feeling safe.

It is possible that this is also the case for staff: that an open and responsive relationship with patients may allow them to draw less on discourses of mental illness and violence, and more on discourses of care and safety. These discourses may then partly shape the ways in which staff interact. This is not adequately addressed in the current literature, and highlights the need for further research into the effects of discourses.

Discourses can be defined as “sets of statements that construct objects and an array of subject positions” (Parker, 1994: p245) which inform different ways of being in and understanding the world. The analysis of discourses allows the implications of associated subject positions (such as 'potentially dangerous mental patient') to be explored, and how these implications shift when different discourses are engaged in.

Where the concept of 'relating' is discussed from a staff perspective, it has been professionalised and theorised in a way that is not evident from service-user



perspectives. For example, in a grounded theory study (Morse, 1991), six types of relating were named between nurses and patients in physical health environments in Canada. Two of these were forms of unsatisfying relationships, where one party did not feel willing or able to invest or trust in the other. The remaining four types were 'mutually satisfying', meeting the needs of both parties. These were named, in order of involvement and intensity, 'clinical', 'therapeutic', 'connected', and 'over-involved'.

A 'clinical relationship' was defined as the nurse applying treatment, and the patient being satisfied with no further expectations. In 'therapeutic relationships', the nurse views the patient foremost as occupying a patient role, but also recognises that they are a person outside of this environment. This fits with the patient's expectations of the treatment of illness as the focus of their relationship. This type of relating was thought by Morse to be considered 'ideal' by training providers and nursing administration. In 'connected relationships', a nurse views the patient as a person first and as a patient second, while maintaining a professional stance. Mutual trust is an essential feature, the patient feels that the nurse has gone the extra mile for them, and that they matter. In an 'over-involved' relationship, the nurse gives too much of themselves, being so committed to the patient that maintenance of the relationship overrides the treatment being offered. Relationships spill over into friendships, and the roles of 'patient' and 'nurse' are both relinquished.

This theory suggests that where there is a 'connected relationship', the nurse feels able to 'be themselves' and relate to the patient's humanity, without excluding 'illness' from the patient's experience. This relationship is seen as rewarding and growth-inducing for all parties, and sits unchallengingly alongside the notion of 'professionalism'. This theory may be a useful framework for considering ways of

relating on psychiatric inpatient units between mental health nurses and patients; however such an analysis has not been conducted to the author's awareness.

These reports highlight the necessity and power of relating on wards, and how the quality, presence and absence of different kinds of relating can mediate the experience of service-users and staff. This emphasises the centrality of the staff-patient relationship on mental health wards in regard to positive outcomes and avoiding iatrogenic harm. Arguably, however, extant discourses of care in mental health wards can influence how staff and service users understand that environment and operate within it, constructing social positions for themselves and others (Harre & Moghaddam, 2003).

### **Rationale**

The aim of this study was to contribute towards an understanding of what might act to obstruct valued ways of relating in inpatient psychiatric environments, and of how relating is experienced. As noted above, valued kinds of relating are defined by greater equality and a transparent sense of kindness and care. Where power inequalities are acceptable, individuals with more power are asked to use this to the express benefit of those with less. A Foucauldian discourse analysis (FDA) was deemed an appropriate methodology, as it enables analysis of the influences of power in discourses (Willig, 2008). This study will use FDA to answer three research questions:

1. What discourses are drawn on when staff and service-users talk about their experiences of relating on inpatient wards?
2. How do these discourses influence the availability of social positions that individuals act into?
3. 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 national network of partnership groups offering users and carers training in research skills and volunteer NHS placements.

### **Participants.**

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

### ***Criteria.***

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

### ***Service-user participants.***

Nine service-users (five male, four female) participated in this study, with an age range of 30 - 63 years (Table 1). Additionally, the group facilitator (a staff-member who works with both inpatients and outpatients) was requested to be present in the focus-group by the group. 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. Two participants, Hannah and Pat, also participated in interviews.

**Table 1.***Service-user participant demographics*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Years in contact with services</b>	<b>Last in-patient stay</b>	<b>How many 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	White British	15	N/A	0
Alexej	-	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

***Ward staff participants.***

There were eight staff participants, two male and six female; age range 22-56.

Three defined their ethnicity as White British, two White British and Black Caribbean, two Black African and one Asian (Table 2). Six took part in the focus-group, and two were just interviewed. One focus-group participant was also interviewed.

**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 Mths	N/A	Healthcare Assistant
Sally	24	Female	White British	18 Mths	N/A	Student Nurse
Eloise	23	Female	White British	6 Mths	N/A	Student Nurse
Bola	33	Female	Black African	9 Mths	N/A	Healthcare Assistant
Emily	27	Female	White British & Black Caribbean	3 year	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

**Design and epistemology.**

Focus groups aimed to expose discourses drawn on in a group context, while interviews generated a personal and reflective account. The concept in focus, or ‘discursive object’ (Willig, 2008), was ‘experiences of relating’. FDA was used to analyse the discourses drawn on when talking about ‘experiences of relating’ (Willig, 2008). FDA is a qualitative methodology situated within a social constructionist framework. ‘Discourses’ are networks of meaning constructed through language and social actions, in turn constructing perceived reality. Several discourses may be drawn on in understanding experiences, and may shift over time and context.

Discourses available to an individual limit and expand the social positions and associated actions available to them, ultimately influencing their subjective

experiences of self and other (Willig, 2008). As such, discourses are taken to reflect systems of meaning in wider society. Discourses seen as dominant legitimise power relationships and associated institutional practices, and in a given point in history become seen as taken-for-granted truths (Foucault, 1982), but may be challenged over time by counter-discourses (Howarth, 2000).

#### **Service-user involvement and schedule development.**

Semi-structured interview schedules were designed using interview guidelines (Willig, 2008; Robson, 2002) and through consultation with the author's academic supervisor. Salomons Advisory Group of Experts by Experience (SAGE) gave feedback on the schedules, which was incorporated as appropriate.

#### **Interview schedules.**

Questions in the interviews and focus groups were based on a shared skeleton schedule and designed to be as open as possible, to allow participants to think about their own experiences and use their own language to describe these without being led. The opening question, 'how do people relate to each other here?' is designed to give the participant opportunity to describe the interpersonal environment as they experience it. Whilst the discursive object of 'relating' is introduced, the researcher brings in no other concept. Schedules can be seen in tables 3 and 4 below.

**Table 3.***Schedules for service-user and staff interviews*

1. Tell me, how do people relate with each other on this ward/the ward you were a service-user on?
2. Can you tell me about times you felt you had positive interactions with service-users/staff members? Felt a 'click' with them?
3. Do you feel that these kinds of interactions are supported here? Why?
4. If there were more interactions like this, what would it be like? Would it be different to work here/be a service-user there? 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/work on?
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?

**Procedure.**

The author recruited service-users through attending the group's regular meeting. All interested parties were given the participant information sheet (Appendix J) and asked to make contact if interested. Written consent was sought before the focus group, and participants reminded they could withdraw consent at any time. Interviews were organised through email, and arranged at least one week in advance. Confirmation emails were exchanged two days prior to interview, asking the participant to reply to show initial consent.

The author recruited staff through attending ward meetings. Interviews were arranged by email at least one week in advance, and confirmation emails exchanged two days prior to interview. One staff team was interested in participating in the focus group, which took place during their reflective practice hour. Written consent was sought beforehand, and participants were reminded they could withdraw consent at any time.

Interviews and focus groups were audio-recorded and transcribed by the author. A process of reading and re-reading the transcripts was engaged in, through the six-step model of FDA (Willig, 2008):

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'.

The analysis also drew on discursive analysis (Willig, 2008), attending to rhetorical devices to highlight how positions are justified or supported. This can help to identify discourses and how they are used to legitimise or challenge power positions.

#### **Ethical considerations.**

The Social Care Research Ethics Committee granted ethical approval and Research and Development approval was obtained through the local NHS Trust (Appendices B and C). Feedback included that attention should be paid to elements of risk of harm to the researcher, risk of distress to participants, and to consider the Mental Capacity Act when seeking consent.

#### **Quality assurance checks.**

As described in a recent Cochrane Review (Hannes, 2011), there are four main aspects of qualitative research to be assessed in quality appraisal: credibility, transferability, dependability, and confirmability.

#### ***Credibility.***

The primary supervisor, who is experienced in the use of FDA, provided audits of data interpretation. Steps were taken to promote reflexive awareness during analysis, including 'bracketing interviews' (Aherne, 1991; Appendix E). Verbatim quotes are used throughout the write up of results, and due attention paid to reducing biases in the use of quotations from particular perspectives or participants.

#### ***Transferability.***

Appropriate demographic information is collected and discussed, providing contextual background information and thick descriptions about participants and

environments included in this research.

***Dependability.***

For improved traceability of research decisions, appendices G and H provide an example of an annotated transcript and coding book of the analysis for one focus group. Further, a research diary was kept (Appendix D) and a mind-map of the analysis in development can be seen in Appendix I.

***Confirmability.***

A documented process of ongoing reflexivity assisted the researcher in grounding the analysis in the data. This enables an enhanced awareness of beliefs, experiences and associated discourses, which may introduce potential interpretative biases to be noted in analysis (Fischer, 2009). In this instance, beliefs regarding the potential transformative power of talking, and in relationships as fundamental to the ways of engaging with internal emotional worlds were of particular relevance.

**Results**

Three discourses were seen in considering the discursive object of 'relating'. The most dominant was the 'medical-technical-legal discourse', with two counter-discourses; 'ordinary humane relating' and 'person-centred'. Tensions between these discourses were noted, with subject positions informed by a wider 'civil rights' discourse. Discursive constructs, associated social positions, and consequences for the experience of 'relating' and tensions/dilemmas (Billig, 1988) between discourses will be highlighted.

**Medical-Technical-Legal Discourse**

This was a major feature of all transcripts. All participants' first recorded utterances positioned people as 'patients' or 'staff' to inform how they could describe relating. These terms immediately position people as 'ill' or 'not ill', making each

party different by definition. This immediate naming of taken-for-granted positions and associated restrictions on relating exposes the strength of this discourse.

From a 'staff' perspective, relating as experienced under this discourse was constructed as a means to an end, a way of enabling the patient to receive the technical, medical or procedural treatments to make them better. Relating enables staff to gather intelligence regarding the severity of illness and measure the impact of treatment upon it, similar to tests of physical illness. This positions staff as empiricist scientists, examining and assessing the patient for particular pathogens. Staff hold the power to define what is or is not 'illness', and the associated treatment regimen.

*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 focussed 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 [...] We use bits and bobs from everywhere and make most use of it (L224-238)*

This positions patients as passive recipients, with little or no power in defining how they understand themselves and their experience. Interestingly, terminology from psychological practice is used alongside medical terms. This constructs psychological techniques as a set of tools to be used for a purpose selected by staff, removing the intended development of collaborative understanding.

Staff also recognised that patients might notice being related to for the sake of information-gathering, and find this unpleasant:

*Staff focus group, Marika:*

*If you're just sitting there and you want them to feed you information and it's not a two-way street then the patient's not going to feel comfortable or like they can trust to have a conversation with you. (L162-165)*

To this end, the use of professionalism was considered somewhat flexible, and the importance of 'rapport' in the service of intelligence-gathering became noted.

*Staff interview, Amy:*

*If you can sort of enable a patient to feel at ease and reasonably confident, there's that potential to gain information from them that might just be really useful in terms of treatment and helping them to recover. (L79-81)*

Developing rapport was spoken of as a technical process, again using techniques from psychological models such as Cognitive Behavioural Therapy (CBT) and Humanist Counselling. Techniques were divorced from their epistemologies and used as tools to get the job of rapport-building done in an objective way.

*Staff interview, Aardash:*

*It goes hand in hand [knowledge and compassion]. And the knowledge comes with time and experience- it's something that you read, stays in your repertoire and you're digging it out all the time. \*tshh! \*tshh! [gesticulates pulling tools from a box] it's your tools isn't it. [laughs] it's the shovel hammer and the brick layer, it's your knowledge. (L425-432)*

The experience of being on the receiving end of this was commented on as unpleasant, as techniques over-rode personally meaningful interactions.

*Service-user interview, Hannah:*

*[ward round] with five people, and I had no idea what was going on. I was really distressed by that [...]you end up telling them what you think they want*

*to hear. That was really horrible. That stayed with me that memory actually, of just opening the door and walking in and just, erm, just seeing all these people there and the expectation [...] thinking 'oh god, what do they want from me, I can't do whatever it is they want - I don't know!'* (L81-89)

Relating was constructed as helping to impart medical knowledge of the 'reality' of illness, diagnosis and prognosis to service-users, carers and families. This enabled families to understand their relative and what is achievable by them within limits imposed by their illness. This positions staff as responsible experts, imparting 'correct' information about a person's 'illness' and predictions for their future to un-knowledgeable family members. Patients are not legitimately able to hold knowledge about their experiences that is different to that proffered by the 'expert'. This was associated with feeling as though one's account of oneself as a service-user was not believed, making them intrinsically untrustworthy as people.

*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 talk- to be believed. Whereas on mental health [sarcastic tone] whose going to believe them anyway?* (L438-440)

This quote, taken from the focus group, invokes a shared belief that staff routinely dismiss patient views, exposing a process of 'othering'. The use of this rhetoric serves to cement solidarity within this group and positions the facilitating staff member, for whom appreciation was expressed elsewhere, as somehow different to other staff. Whilst it may appear an unnecessarily extreme statement, the requirement for such a strongly expressed position possibly signals the level of powerlessness that these people have at times felt, and unites a shared sense of oppression.

Overt expressions of mental distress were constructed as emergencies by staff, and associated with a decrease in the effectiveness of relating.

*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, anything can happen. (L56-58)*

For service-users, the reverse was true: the more acutely distressing a mental state, the greater the need for interpersonal interaction.

*Service-user interview, Hannah:*

*I could just tell he was really distracted and, basically he had a job to do [staccato] and I just happened to be the person he was having to, you know, so there wasn't really any sort of, interaction or anything [...] you're in a very distressed place emotionally anyway so I suppose you need, almost like overkill perhaps really, I don't know, I don't know but- or a smile might be nice I don't remember him smiling. He wasn't very happy- he seemed quite grumpy and I thought 'oo just don't say anything'. (L469-478)*

The medical-technical-legal discourse seems to negate 'care' as potentially impactful on extreme states of mind, privileging medication as the correct treatment. From this position, staff can not legitimately engage in forms of caring expected by service-users, instead being limited to "barrier nursing" (Aardash, L207), restraint, and fast-acting sedatives. Ordinary talking on its own ceases to be 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, lets say benzodiazapine, then say half an hour later a little bit of chat, it works. (L214-217)*

This notion is directly informed by the construct of mental illness as a disease, particularly noticeable through use of 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 act in bizarre ways. This acts as a veil, which staff are compelled to subdue before relating to the real person underneath.

*Staff interview, Amy:*

*I think sometimes 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)*

‘Illness’ also alters the patient’s sense of reality, and their appreciation of self and other is distorted as a result. Relating was described as a way of telling the patient what their true personality actually was, almost trying to convince them 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, and a rewarding element to the job. Legitimate relating is then limited, waiting for the illness to subside before the real person can be engaged with. This was described by service-users as:

*Service-user focus group, Mohsen:*

*It’s very plastic, it’s very false, there is no relationship [...]. any*

*expression of emotions is kind of forbidden I'd say but, if sometimes you see someone actually going to that length [trying to relate] you kind of dis-believe it you don't want to believe it you still think there is a glass wall between us. (L55-59)*

Patients were described as rapidly changing from stable to unstable as a result of illness, with no external trigger. This upholds the view that because illness alters brain chemistry, patients do not have control over their behaviour and responsibility is held by staff instead. Consequently, a medico-legal framework was drawn on. Staff described themselves as holding expert duty of care, an essential element of their role, handed down by higher authorities.

*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. (L167-169)*

Staff also described having to watch their back, as it becomes unclear who they can trust. Staff were fearful of patients responding in a 'negative' way, as this could result in accusations being made, for which staff could lose their job.

*Staff focus group, Bola:*

*If you are having a sort of rapport with patients, I think sometimes because you are working with mental health patient, who, at this point in time you think they are to a certain level, erm, level headed, they are settled and everything and the next minute [clicks fingers] something snaps in that, they are saying something else. (L172-175)*

The edges of appropriate relating are defined by these frameworks, and the idea of relating as a one-way process from expert to patient is reinforced. This limits



and constrains staff, forcing them to act as legally accountable agents of the state in the course of their day-to-day work, preventing other forms of relating emerging without dissonance. Consequences of these positions are of all parties feeling disrespected, unheard, uncared for and untrusted.

### **Discourse of Ordinary Humane Relating**

A competing discourse of ‘ordinary humane relating’ captured experiences of ordinary care, compassion and concern reminiscent of a sense of kinship. This was not contingent on technique, but constructed as a natural and automatic way of being, developing through life experience rather than training.

*Staff interview, Amy:*

*You know theories whatever that you can sort of draw on, but erm, 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, you know and the role, and it becomes almost automatic really. (L339-341)*

Valued interactions were quite mundane and ordinary. Service-users described how sharing purposeful activities with staff helped each person to understand the other better, and improved a sense of trust and safety, as if re-humanising a hitherto alien other.

*Service-user interview, Pat:*

*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 care was not available with staff, it was sought between service-

users instead, reminiscent of parentalisation and legitimising ‘othering’ between staff and service-users formed through constructs of the medical-technical-legal discourse.

*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)*

*Service-user focus group, Mohsen:*

*It was kind of strange to have a relationship or, need- it kind of made that need more acute, to have that amongst ourselves. (L64-65)*

As a staff member, ordinary humane relating was described as a way of knowing you are making a difference, that you're trusted and that the relationship has potential.

*Staff focus group, Sally:*

*It's nice when you come in and people feel comfortable to talk to you, [...] 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)*

Service-users spoke about staff with lower levels of qualification or training as qualitatively different to their seniors. They were described as people who related in an ordinary way, who would spend time with them, talking, joking and make them feel as though they mattered through ordinary interactions and simple conversations. Conversely, senior staff were seen 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 got in the way of a satisfying relationship.

*Service-user focus group, Pat:*

*[nurses] they're just ticking boxes doing paperwork. They've got no time for you [...] [HCAs] they're the ones that are more human cos they, they've not been programmed yet [...] the actual paper shufflers and, you know, the people that don't talk to you, just the faces behind the boards. (L120-121; L483; L526-527)*

From a staff perspective, ordinary moments of relating seemed to happen by surprise, and affected them on a profound and personal level, staying in their minds and making them think.

*Staff interview, Aardash:*

*I have learned a lot from patients. There was a patient who was on the ward one day and he was reading the bible or something, then we got into a conversation and he said to me "if you don't believe in religions or some sort of philosophy, then there is no difference between you and a cockroach". And I looked at him, and I went home and thought about it and thought, yes, then we're human beings otherwise we're an animal, an insect. (L380-385)*

One staff member, Marika, spoke of building relationships with patients as a tonic to her inherited stigma. She spoke of seeing how life events can interact, leaving people in positions of great vulnerability, and how relating in an ordinarily humane way exposed the gossamer thread between service-user and service-provider. This questions the need for the hierarchy inherent in the medical-technical-legal discourse, giving rise to the potential for a co-operative framework of caring, without hierarchical structures and boundaries.

### **Tensions/Dilemmas**

These juxtaposed discourses reveal tensions between ordinary acts and the environment in which they occur that were sometimes hard to verbalise.

*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– maybe, to me, it was not normal 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. The ordinariness of surface-level relating was experienced by Hannah as somehow odd, as if it missed the point. There was a feeling that despite this way of relating being important, there were other kinds of relationship that were needed and expected in a 'treatment' environment.

*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)*

Others countered this dissonance by drawing on a reactionary discourse of civil rights. Egalitarianism, a right to be told how your problems can be understood, and a right to be told what treatments are available to you were highlighted, along with a demand to be listened to without being pathologised, and be involved in decision making about your own treatment.

*Service-User interview, Hannah:*

*I sort of came away thinking I have no idea what happened just then. I really don't know I didn't understand what had happened, what they had thought*

*about me, what they'd written down. I think it's the not knowing, or not being explained to that's the problem you know, I think if people tell you stuff then you can sort of [...] otherwise you're just floundering around thinking allsorts (L288-293)*

The construct of 'second class citizen' was raised frequently, as service-users felt they had to prove they deserved kindness, to be believed, and that they were not wasting resources. This discourse positions people needing care as unquestionably deserving, and as having needs that are as valid as other vulnerable people in pain.

*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 concerned and puzzled by reactions from qualified staff when seen relating to patients in ordinary ways.

*Staff interview, Marika:*

*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? (L104-108)*

When talking about endorsed ways of relating, Marika comments that:

*Staff focus group, Marika:*

*[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. This exposes the damage to relating that the medical-technical-legal discourse can invoke. Those positioned as ‘staff’ develop a niggling doubt that ‘patients’ are somehow not normal, and relating to them as if they are normal is potentially dangerous: You cannot trust your instincts to relate to people if they are in the subject position of ‘patients’.

One nurse spoke about relating as an intrinsically human drive that could not be helped, although this did open the door to potentially overwhelming distress and should be guarded against in the role of being professional – echoing service-users’ experiences of professionals somehow not being human.

*Staff interview, Aardash:*

*[The drive to relate] can act against you as well. You can get too emotional [...] It can act to help you in your work and it can also act against you. You can become too sensitive - hypersensitive in an environment which is very very volatile. (L462-471)*

### **Person-Centred Discourse**

While ‘ordinarily humane relating’ was a desired and valued experience, service-users spoke of purposefully therapeutic encounters as the expected, and missing, treatment for their problems. A ‘person-centred discourse’ privileges ways of relating that are meaningful, connected and emotionally open and with a purposefully

therapeutic aim defined by the service-user. These ways of being allow the whole personhood to emerge in a relationship, inclusive of emotional pain. This inclusivity allows an experience of being understood in a way that relieves distress, offering containment and hope that the pain will not last forever.

*Service-user interview, Hannah:*

*He was very gentle with me, erm, and explained what was going to be happening, and why- he was non-judge- judgemental 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)*

The notion of a 'proper interaction' was described several times by service-users, and although difficult to define it included the sense of relating on a personal level, where both parties want to connect and have an impact on each others' internal worlds.

*Service-user focus group, Mohsen:*

*When I myself worked there and I saw some of my colleagues were truly genuinely they wanted to connect wanted to connect, to comfort. (L73-74)*

Having access to someone who wanted to listen and hear your story enabled the speaker to become visible and allowed their personhood to emerge within that relationship, with their distress understood as a reaction to their situation.

*Service-user interview, Hannah:*

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

This fostered a sense of being valued, heard and understood. There were

expressions of gratitude and relief at being found after being lost in a sea of impersonal interactions.

*Service-user interview, Hannah:*

*I was grateful, actually. I was— that was where I was coming from at that point I was just grateful that anybody would have been remotely nice to me- which was why I wanted to cling on- you know metaphorically cling on to his leg. (L502-504)*

Achieving this kind of relationship was talked about by staff as difficult, but fulfilling when it was possible. It was as though this way of being would inherently necessitate the staff member engaging with their own personal experience. Although this could be an asset in terms of allowing greater authenticity and empathy, it was also a feared liability, allowing overwhelming emotions in. This is not compatible with the notion of being ‘professionally boundaried’, exposing tension with the medical-technical-legal discourse, as though by controlling the urge to empathise, risk might also be controlled.

*Staff Interview, Aardash:*

*We get immune to it. I don't think we realise ourselves how much, er, 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. So. Perhaps we, underestimate our own capacity to take that stress, and you have to be strong, you have to be strong I mean 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)*

Further, the highly pressurised atmosphere, large workloads and



administrative demands were cited as major stressors. The pressure that this puts on staff reduces their abilities to think, preventing them from accessing the resources needed to be emotionally available and open to others' experiences.

### **Discussion**

This study revealed rich data regarding the discourses drawn on by staff and service-users in understanding the experience of relating on inpatient wards. Three main discourses were seen: 'medical-technical-legal', 'ordinary humane relating' and 'person-centred'. A reactive discourse of 'civil rights' was seen in the tensions and dilemmas between the dominant and counter-discourses.

The two strongest discourses, 'medical-technical-legal' and 'ordinary humane relating', expose significant tensions and dilemmas faced by both service-providers and service-users. As these discourses stem from competing ontological positions, they hold distinct implications for the meanings, functions and possibilities of relating. Where the medical-technical-legal discourse constructs relating as a technique or tool to extract information from/impart information to a patient regarding their 'illness', the ordinary humane relating discourse constructs relating as an expression 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 'ill people' have capacity to relate in ordinary ways, and whether 'a human in distress' responds to relating in the same way as 'a human not in distress'.

The strength of this discourse leaves little room for ordinary relationships to emerge legitimately. Where staff did discuss relating in ordinary ways, it was spoken of with discomfort and dis-ease, with a niggling doubt that 'patients might not be normal' or 'ordinary relating with an ill person might be harmful and dangerous'.

When the person is ‘behind the illness’, they can’t be related to until the illness is subdued. These discourses existing within one environment promotes inconsistent and confusing experiences of what appropriate relating entails.

The implications of the ‘patient’ being not-quite-normal legitimises the practice of expert staff being professionally trained in specialist techniques to engage ‘patients’ in specific ways. These techniques are often divorced from their epistemological origins, operationalised instead through a technical paradigm. This was more clearly the case with psychological techniques; however medical terminologies from varying contexts were also named (e.g. barrier nursing, from quarantine and infection control). Consequently, staff are of the belief that they are drawing on evidence-based interventions; however the influence of the assumptions generated through the medical-technical-legal discourse is such that they have been morphed into a top-down, expert-driven application of treatment. This alters the ‘patient’ experience of interactions, where the prominence of technique over ordinary humane relating has left this particular service-user group wondering whether professional training actually makes staff worse at relating. Consequences for all parties, regardless of position, were of feeling disrespected, unheard, uncared for and untrusted.

Further, the administration associated with the medical-technical-legal discourse consumed the time and energy staff had to spend with patients. This resonates with findings from Zeeman and Simons (2011), who named a ‘biomedical discourse’ as shaping the role of a nurse as “task-saturated”. Nurses were seen as representing the tensions between the biomedical discourse and a ‘psychological discourse’, where acts of “being with people” were valued.

Highlighting the dissonance in the lived-experience of these kinds of relating,

interactions constructed through the discourse of ordinary humane relating were noted as particularly memorable. The strength of feeling underlying these experiences signalled how important it was to participants to have every-day kinds of relating available, particularly from the user perspective. This was associated with a sense of being 'visible', recognised, and re-humanised, as also described by Clarke (2006). This experience of 'becoming visible' is taken as describing the shift from subject position of 'patient' to 'distressed human', as the discourse drawn on changes. This positioning of 'distressed human' exposes the humanity of suffering, and the gossamer thread between service-providers and users. For staff to engage in this kind of relating, no training or theoretical influence was needed, informed instead by life experience.

This ordinary kind of relating was not 'treatment', but the basis from which 'treatment' relationships can grow. This kind of 'treatment' relationship was constructed through a tentative engagement with the person-centred discourse, and seemed reminiscent of 'connected relationships' defined by Morse (1991). This discourse was mostly noted through comments on its absence and desire for its presence.

### **Clinical and Theoretical Implications**

The gap between service-providers' and users' expectations of the role of emotional openness and ordinary humane relating seemed to the service-user group to be potentially easily addressable. The value of management systems legitimising ordinary ways of being on the wards was highlighted, as was the need for transparency of what roles staff can actually be expected to occupy. This supports findings from Woods and Springham (2011) and Gilbert et al. (2008), particularly expecting staff to be transparent and proactively engaging. Resources were

highlighted, with staff noted as too busy or stressed to relate in a containing way, similar to findings from Holttum et al. (in preparation).

Service-providers should be supported to address these stumbling blocks practically, whilst also recognising the positioning that occurs on inpatient wards, and the associated implications. One possible obstruction in improving satisfaction is that of subject positions associated with the medical-technical-legal discourse. Where relating was constructed through this discourse, it became harder for ‘bedside manner’ or ‘therapeutic alliance’ to exist. A particularly noticeable example of this was the dominance of the inherited notion that you can’t talk or relate to people who are overtly expressing distress. A shift in the dominance of this discourse may pave the way to more generative experiences of relating, supporting the development of more therapeutic encounters.

Clinical Psychology is perfectly placed to facilitate such a stance and promote consideration of how different ways of being and understanding influence how people relate. This can be achieved through reflexive conversations with ward staff, and influencing strategic planning, management and training organisations to consider the wider implications of the discourses they draw on when organising systems.

### **Future Research**

These findings highlight some direct unwanted effects of the medical-technical-legal discourse on relating. Further research is needed to consider what relevance this may have to iatrogenic harm associated with some inpatient environments (Holmes, 2002). It would be beneficial for research to consider how services may transition to embrace discourses that enable helpful forms of relating, and what specific elements are needed for this. Inpatient wards may benefit from considering how community services are engaging in discourses of personal recovery,

and moving away from the notion of clinical recovery. Research on the impact of training on how relating between staff and service-users is constructed is also indicated.

### **Limitations**

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

It is also possible that staff members might talk about their ways of relating with an emphasis on 'evidence-based practice', as this is a particularly strong zeitgeist in the present climate. 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 constructs of relating generated through a medical-technical-legal discourse are dominant in inpatient psychiatric units. A competing discourse of ordinary humane relating was noted, with relating constructed as egalitarian and seen through day-to-day experiences of emotional openness and togetherness. This was overshadowed by the medical-technical-legal discourse, as seeds of doubt regarding the trustworthiness of service-users were sown and a fear of relating to patients 'as if' they were normal might make them more ill. Despite this, 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/distress could be heard and contained by staff. A cultural shift is required, where relating can be legitimately co-constructed as meaningful, and its healing power rendered visible.

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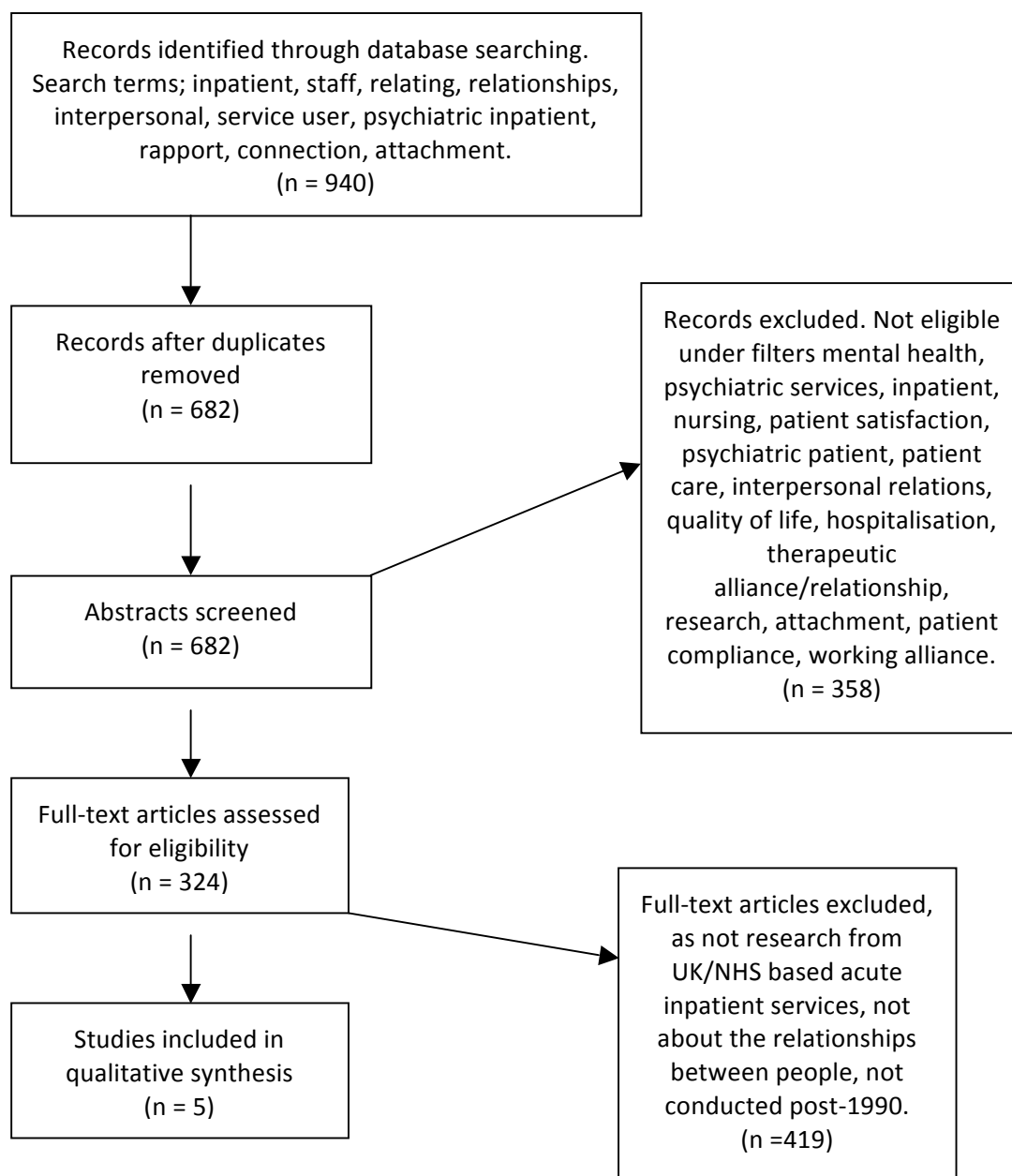
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**Section C:**

**Appendices of Supporting Material**

**Appendix A. PRISMA Flow Diagram for Section A Literature Review<sup>2</sup>.**

<sup>2</sup> From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

**Appendix B. Research Ethics Committee Approval Letter**

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**Appendix C. R&D Approval Letter**

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**Appendix D – Abridged Research Diary**

June 2013

Reading methodology of FDA [Foucauldian Discourse Analysis]. Trying to grasp what my DO [discursive object] actually *is* now, its morphed somewhat. It was ‘connectedness’ when I started the proposal, and that’s what Salomons have signed off; however that notion was seen as too challenging by the SCREC [Social Care Research Ethics Committee] panel, and they’ve requested I change it to ‘positive interactions’. I guess it’s the same sort of idea that I’m engaging in, so really the essence of the DO hasn’t changed, but it feels like the terminology keeps shifting. Its really curious that the SCREC panel didn’t even like the term ‘click’, even though it came from the service-user feedback as a more meaningful term than ‘connectedness’. If I accept this shift in the name of the discursive object, am I changing what discourses I might be able to access? I am primarily interested in positive experiences of relating, but I also don’t want to limit the available data or close down people’s responses by using a term like ‘positive’. Will need to discuss this with my supervisor, but my feeling now is to just use the term ‘relating’ in the interview, and use ideas of positive interactions, connections and clicks as prompts or cues if needed.

December 2013

First focus group is done! Relief! I got really excited by that, it actually feels like I’m going to be able to produce something interesting and worthwhile. Some really interesting responses from [service-user group]. They really struggled to get to grips with the idea of positive relating on wards. I wonder if, to some degree, they’re almost not ‘allowed’ to say that positive things about inpatient wards exist. If the staff on wards are all bad, then it explains away all bad feelings. I hope some of them will come to do interviews. There are a couple of people in particular I think would have really interesting stories to tell me. I also wonder how being a [service-user group] member might bias the way people tell their stories. Thinking about it, it really is quite a political act to be a member of a group like this, and is a very clear reclaiming of power and status. I wonder how much this is in the conscious awareness of the group, and whether this will influence the discourses I see in the transcripts. I’m aware that my own politics/Politics could influence the way I see things in the transcripts too, particularly my leanings towards approval of social action and disruption of established ways of being.

December 2014

My second supervisor has disappeared. In recruiting staff for the focus group, they said “oh we can use the time we would have used for the reflective group in January, now that [Second Supervisor] is on maternity leave we won’t be having it”. I hadn’t heard anything about this, and it seems she went yesterday! Massive panic, but spoke with [primary supervisor] and she suggested I chat with [Service-user group facilitator] to see if he knows anybody. Feeling quite hopeless again, and like this project will never get off the ground. [Service-user group facilitator] has said that he would like to take the role of second supervisor. I’d be really happy for him to do this, he seems like a very knowledgeable and approachable person, but I’m concerned it might not be right because I’ve already interviewed people from his [service-user group]. I’ll have to be careful to ensure I don’t expose people or breach confidentiality. Will discuss with [primary supervisor], if it seems OK from Salomons’ end, then I will accept his offer.



January 2014

Transcribing staff interview 1. This is really hard work! I'm really surprised at how many responses I'm having to the content: emotionally and intellectually. It's a very different experience to sitting in the interview. I've found myself feeling annoyed with this participant, and with myself as interviewer. She keeps giving really bland, one-dimensional answers to my questions and I don't think I'm pushing her enough to give more detail. I didn't notice this at all during the actual interview. I was really surprised when she couldn't talk about any examples of relating or connecting with a service-user. It really confused me at the time actually, I didn't know what to do with that response. I think I had quite high hopes for her interview, because of her training I thought she would be more thoughtful about the impact of relating. I was disappointed when the majority of her responses were about relating as a way of gathering information from people, and how this can make you more popular in the team. Perhaps there is a much stronger rhetoric of self-protection and survival on these wards than I had anticipated. I also really felt like I'd crossed a line with her when I asked if she experienced any barriers between her and patients. It was as if I'd accused her of something really bad. Perhaps there is an unspoken acceptance, even support, of the 'us and them' barrier, which is threatening to name or challenge?

January 2014

Interviews with [service-user group] members have gone well I feel. Some really interesting and moving accounts of positive interactions on the wards. It was almost like they'd never stopped to consider what the experience was actually like. I did have to be quite active at times, particularly getting people to focus in on describing a specific interaction and what that was like. I feel much more confident now about interviewing than I was in the first one. My feelings are fluctuating a lot about the content though. At points I feel really excited by them, and remember some really useful interesting information that somebody told me. Then I think there's nothing of any value in there at all, and the participants have missed the point, they didn't understand my questions and I let them go too far away from the topic. I wonder if this links with my earlier feelings of uncertainty about what the terminology for my DO should be. It also seems as though relating is just a very slippery topic, and I don't think I'd appreciated just how politically loaded and sensitive this subject is. There does seem to be a certain line that can't be crossed, none of the staff participants so far will criticise their wards; in fact the opposite, they keep saying how great everyone is. Sometimes it seems too much, and I wonder if they're actually telling me the truth about their thoughts or if they're telling me what they think I want to hear. I also wonder if they're just telling me things to make themselves look like a modern, open, psychologically-minded team.

January 2014

Doing the transcript for staff 2 now. Massive sense of disappointment! I really enjoyed talking with this guy, but now listening and typing back it all feels very thin. Sort of like a veneer of psychological or philosophical thinking, with concrete medicalisation of experience underpinning it. I wonder if some of this might be him showing off the big words he knows, it felt quite peacock-esque at times. During the interview I did feel impressed by him, and pleased that someone so thoughtful was in a position of influence in the ward. The way he was with me somehow lacked a sense of authenticity, until he started to talk about personal experiences with service-users,

where he actually felt impacted upon by their existence. It seemed that issues of loss were pertinent for him. I got a sense that he was wanting to be more in control of his personal responses to service-users than he thinks he is. When he was talking about the service-user who committed suicide, he spoke of their relationship with real joy in his voice. Again though, he couldn't bring himself to make any comments about how things could be improved, or that there was any cause to feel uncomfortable with the way the systems he engages in function. I wonder if I am able to reach the 'true' ways that relating is considered in these institutions. There seems to be so much guardedness around the whole concept, and I don't quite understand why that is. What is there to be guarded from?

February 2014

Conducted staff focus group. Very odd experience. Arrived on the ward and was 'greeted' by a nurse who silently walked me up the ward and left me alone in the unlocked nursing station. It took 20 minutes, but eventually someone came back to the nursing office so I could find who wanted to take part in the focus group. I was really surprised that a) it had been put in the ward diary and stayed there; b) people had taken and read the information sheets; and c) people were actually volunteering to take part. It suggests there's something about this topic that people want to talk about, that it stimulates them somehow. Thinking about it now, recruitment overall hasn't been as difficult as I had expected, for the staff at least. It turned out the CQC [Care Quality Commission] had come for an unannounced inspection of the ward, so everyone was very busy. In spite of that, 6 people attended the focus group. I was annoyed when 3 of them, at various points, were removed for different reasons, all to do with the CQC; but again, I was surprised that the ward manager hadn't cancelled the focus group. It really makes me think they see something valuable in this research. I found some of the comments made by one of the HCAs really difficult. She was talking about how staff had to look after themselves, because patients are just out to get them into trouble, and senior staff have no tolerance for getting things wrong. She even made a comment that seemed to equate having a 'person centred' relationship with a service-user was akin to incest. I struggled to know where to begin questioning statements like that, and I worry that I've missed out on some really important data. Interestingly, I feel completely different towards the other HCA. The things she says really chime with how I think I used to talk about human rights and politics when I was a teenager/young adult. I really want to take her under my wing, and protect her from all the opposing views that she says she struggles with. I will need to be mindful of this when I'm transcribing, and think carefully about how I code her contributions.

February 2014

As I'm trying to do this FDA, I'm struggling to feel confident in my decisions. I wonder if I'm just making things up, or if what I see is an accurate representation of the data. I've tried reading other DA publications, and I can't quite believe that what I have will turn into that! I don't understand how they've managed to get data like this to seem so succinct and make so much sense. There's a lot of hidden meanings in my transcripts, and it seems like discourses are hiding in plain sight almost. When I first transcribed all the recordings, I could hardly see anything of a medical discourse in them which really surprised me. It took a while, but as I was going through it I began to see that it was so strongly taken for granted, people didn't even bother naming it. Very few medical terms were actually used, but the latent content, the manner in which relating was spoken about, feels very strongly medicalised. I'm wondering if I

really can do this, it seems too easy and too complicated at the same time. It reminds me of A-level Chemistry, when I kept failing exams because I couldn't believe the questions were asking anything I could answer easily and looked for over-complicated answers which were inevitably wrong. I need to keep bringing myself back to the research questions, and keep checking my coding and discourses with the actual data. Don't over-complicate it, and have confidence that the data is there and that I have the ability to name it.

March 2014

Feedback from supervisor is really helpful. It seems like we're using slightly different terminology, but essentially seeing and describing very similar constructs. I really like the language my supervisor uses to describe things, she somehow manages to capture a real live sense of what's going on, whereas my definitions feel a bit stayed in comparison. I'm feeling somewhat impinged upon by quantitative/empiricist ideas of 'the right' name for things, unveiling the true state of affairs. It really feels like my supervisor is able to move much further away from those ideas than me, and engage much more easily in the social constructionist epistemology. Its strange because, on the whole I don't struggle with those ideas, but somehow in trying to write all this up and turn what I've been thinking into text I lose the words and feel as if I need to be doing it in a more 'sciency' sort of way. Despite this, I am actually enjoying doing the research. It feels such a shame that I'm having to shoe-horn it into evenings and weekends, around placement commitments. I wonder if I would find it easier, or be making better quality research, if I was able to just focus on this alone.

**Appendix E – Bracketing Interview Transcript, Pre-Data Collection**

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**Appendix F – Bracketing Interview Transcript, Post-Analysis**

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**Appendix G – Example Annotated Transcript – Staff Focus Group**

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**Appendix H – Analysis of Transcript – Coding Book for Staff Focus Group**

**Stage 1** of analysis shown in annotated transcript (highlighted areas)

<b>Discourse Name:</b> Medical-Technical-Legal Discourse			
<b>Discursive Constructs – Stage 2</b>	<b>Action Orientation/function s of constructs – Stage 3</b>	<b>Subject Positions – Stage 4</b>	<b>Practices (stage 5) and ways of understanding (stage 6) made legitimate/illegitimate</b>
Different between staff and patients	Separates and delineates. We are not the same as each other – or are we? Laughter indicates dilemma.	Staff as medical experts, patients as ill and in need of care	Patients cannot care for themselves, staff must take this responsibility from them
Mental illness makes patients untrustworthy	There are no environmental/interpersonal triggers for changes in behaviour – intrinsic to the patient's biochemistry. Never know what you're going to get.	Patients are volatile; relating is stressful	Legal accountability is taken by the staff for actions associated with illness.
Staff use skills to control the ward – must not let the boat rock.	Staff must do everything they can to maintain control over patients' actions.	Staff hold power and skill; relating is a technique that staff do to patients. Staff are legally accountable for anything that happens.	Staff must use specialist techniques to control patients' illnesses and associated behaviours.
Staff not allowed to loose cohesiveness of the team, must act with unitary objectiveness; Don't go native	Keeps staff in line, fear of being outcast. Makes it hard to question the status-quo.	Us and Them – othering. Patients are dangerous, we need to act as one to stay in control.	Can't trust patients when they are ill, because they are out of control.
Medical emergencies	Makes the job exciting, even fun like a helter-skelter slide. We are important and skilful.	Staff must act like an A&E crash team	Actions associated with medical emergencies (e.g. injections, restraints, etc) are legitimated.
Staff are objective at all times	The truth of the matter is that patients have a biochemical	Staff as professional and the same at all times of day and	Legitimises ideas of patient being changeable, staff are consistently

	illness. We are scientific and can control ourselves, not like them.	night	scientific in their observations.
Boundaried techniques for relating	Enables the tasks to be completed without an emotional impact – providing immunity to the distress around us.	Staff must hold back their personality – it is not professional to be yourself.	Legitimises objective scientist behaviours e.g. observations. Prevents staff from being themselves, makes it harder for them to relate to anybody.
Staff are too busy doing important work to relate	We have a job to do, and we have to answer to higher powers if we don't do it. Got to tow the line.	Staff are important, relating is not valued.	Tasks become legitimised things to do on the ward, talking to patients becomes de-legitimised.
Information/intelligence gathering	We need information to tell us what illness the patient has, how ill they are and if the treatment is working. Like a biological test.	Staff as owning patient information, relating is a way of getting it out of them. Patient as mine of information.	Any act associated with gathering and disseminating information to the team is legitimate.
Talking to patients is only about completing tasks	Conversations are on staff's terms. Staff hold power to decide what to talk about and when, its all about getting the boxes ticked, then I can go home knowing I've done a good job. Patients can cause me stress if they don't give me the information I need to get my tasks completed.	Tasks are more important than patients.	Tasks become legitimised things to do on the ward, talking to patients becomes de-legitimised.
When people don't get on, its an emergency that needs to be de-escalated	Staff have the skills and responsibility to control social situations and maintain order. Reminiscent of a prison warden.	Staff are legally accountable. Expressions of emotions are signs of a lack of control.	Legitimises distance/emotional closedness from staff. Makes acts of emotional openness devalued and dangerous.
Authorities tell staff to not get close to patients, they regulate how we are allowed	We don't make the rules, we just have to work with them. Allows staff to distance themselves from the impact of	Staff don't have power to decide how to relate to patients; staff are vulnerable to authorities.	Staff follow the rules to avoid potential punishment.



to relate with legally binding rules	their actions by blaming authority.		
Mental health patients are unpredictable, so they might be predatory and dangerous	Limits what is acceptable to share with patients, and makes legitimises seeking shelter in the nursing office.	Staff as vulnerable to victimisation, patients as dangerous. Staff must protect themselves from dangerous patients.	Patients' behaviour understood as purposefully manipulative acts, other ways of understanding are de-legitimised.
Legal expert duty of care	This is a serious situation we're in. There is real and present danger, and we're on the front line protecting society from danger.	Staff as legally accountable; Patient is not in control of their own behaviour.	Sectioning, capacity act assessments, treatment orders, other state-authorized mechanisms of control. Patient is disempowered.
Uniforms as branding of medical staff	Makes it harder to relate 'normally' or to see patients as 'normal'. Exposes shame.	Patient is exposed as different through clothing, especially when leave the ward.	Grouping – uniforms stay together/separate from patients
It is unprofessional for staff to show their personality at work	We are trained to be like this. We have to fit in, or else we could get sacked. There is a pecking-order too, and if we show our vulnerabilities to other staff, we get bullied.	Staff are just a cog in the machine, easily replaceable.	Prevents staff acting 'normally' – how they would outside of work. Limited expressions of self allowed.
Following the rules of relating makes us more efficient and evidence-based	Staff use objectivity and science to provide the best treatment.	Staff need rules to stop them getting into trouble –if left unchecked we would relate in ineffective ways.	Legitimises abeyance & limits actions outside of rituals of evidence-based practice.
Can't relate to patients when they're being violent, dangerous or rude	Particularly male patients. Need to be careful of what they can do to you if you're a female member of staff.	Staff withdraw, feel afraid and don't want to engage. Patient does not get the containment they need.	Seclusion, segregation, locked wards, observations, distance between staff and patient are all legitimised on grounds of 'safety'.
<b>Discourse:</b> Ordinary Humane Relating			
<b>Discursive Constructs – Stage 2</b>	<b>Action Orientation/function s of constructs – Stage 3</b>	<b>Subject Positions – Stage 4</b>	<b>Practices (stage 5) and ways of understanding (stage 6) made legitimate/illegitimate</b>

Relating is easier with patients	I can get along with them OK, the real madness is within staff.	Patients are normal, staff are hard to understand	Staff acting 'normally' with patients, but confused by staff procedures. Denigration of senior staff.
Sharing demographics makes it easier to relate	Easier to focus on similarities over differences, means we can get close without feeling distressed by our differences.	Difference positioned as hard to overcome	Sticking to people who are similar to you, from a similar background. Beliefs remain unchallenged.
People relate differently because of having different backgrounds	This means I don't have to get to know people who are too different to me, someone else will share a similarity.	Staff should find patients that match their demographics to relate with	Sticking to people who are similar to you, from a similar background. Beliefs remain unchallenged.
Possible when there are fewer tasks	Nice to share some down-time with patients when we're not busy working.	Staff are too busy to act normally	When there are fewer tasks, then we can spend time with patients.
Patients relate well to each other and look after each other without our help	If they can look after each other well enough, I don't need to worry about their needs not being met, which is just as well because I'm so busy.	Positions staff as impotent/unnecessarily in emotional care.	Precludes staff from ordinary relationships with patients.
Relating happens between people naturally	We don't need to think about it, just let it happen.	Its possible that everyone can just get on, we don't need special skills or techniques. Anyone can do it.	Moments of ordinary relating can happen legitimately, regardless of skill-level.
There's a danger of sharing too much if you relate normally	Trying to diminish confusion – we're here to care, which is about sharing; but we're told not to share. Maybe its OK to share a bit.	Questioning authority of powers that be – do I really need to monitor my utterances? Authority say yes.	Self-disclosure about factual events in one's life, but don't tell them too much otherwise you'll get manipulated. Trying to get the balance right, so I can be useful to patients and be seen as good by the team.
A personal need to be warm and open with patients in distress	Its OK for me to follow my intuition. I don't hold back on what I say, this is just who I am and that's OK.	Staff as having a human desire to offer care and kindness	Legitimises being ordinary with patients as being human(e).

There are acceptable limits to sharing and relating	Of course, I'm not going to share my whole life story. But I will share bits of it.	Staff as in control of what they share, able to make decision for themselves.	Legitimises choosing your own level of self-disclosure.
Reciprocal relating	Legitimises self-disclosure – without it, patients would never tell you anything and they could never benefit from being on the ward.	Both parties expected to give of themselves and trust the other; Brings both parties closer & stops staff forgetting that patients are real people too.	Legitimises not trusting patients who don't give enough; legitimises patients' behaviour towards staff who don't give enough.
Relating in your own clothes makes it feel comfortable and familiar	Denial of need and distress of the patient. We're the same.	Both parties are positioned as ordinary people	Legitimises chatting, hanging around, just being together.
Can happen in spite of trying not to, and then you feel connected to the patient.	I'm still a good human-being. My values of care and compassion aren't totally removed.	Staff can accidentally give-in to a human desire to relate; then they are vulnerable to exploitation and need to stop it.	Accidental relating removes threat to professionalism – I didn't mean to, it happened without my control so its OK. Reduces dissonance.
University of life is better than academic university.	As an untrained member of staff, I have just as much (if not better) education as qualified staff.	Un-trained staff are better at relating than trained staff.	Makes un-trained staff feel legitimate in their ways of being – my education is more valid than theirs.
You can only understand patients if you've had problems too	Bolstering self-esteem. Senior staff who think they're better than me and the patients actually aren't.	Shaming those who pretend to have escaped life's adversities.	Privileges a stance of "I know the real world better than you"; legitimises not taking staff seriously if they don't claim adversity.
Just need people skills	I have the skills to relate to patients normally. Some other staff don't, because they lack people skills, and you can't be taught those.	Staff who don't relate to patients don't have people skills – they are inept.	Low/un-qualified staff can act in legitimised ways with people skills, even if they don't have skills from formal training.
Needs energy and resources	Only us young staff have the energy and resources needed to do this job properly. The old staff just get stressed, and we're	Older staff are more jaded and don't have these abilities. Senior staff don't know what they're talking about.	Legitimises sense of grievance junior staff have with senior staff. (goes against Menzies-Lyth 's idea of projecting responsibility upwards –

	not like them. 'We are the young ones' – our view of things is closer to reality,		cultural context? No longer a culture of unquestioned respect for elders?)
Relating is defined by your demeanour and the way you carry yourself	Patients know I'm authentic and genuinely want to get to know them.	Staff as responsible for being open enough for patients to respond to positively. You either have it or you don't. If you do, you're a good staff member.	Puts staff in control of whether they allow interactions to become relationships, depending on what demeanour they show. If staff don't relate well with patients its because they're not carrying themselves in an amenable way.
Small interactions can grow into meaningful relationships	Allows me to say hello to patients as I'm busy with other things. Means that I can say despite being really busy I still tried to talk to them.	Patient is taken seriously.	Brief encounters, just saying hello, interacting whilst doing other things are legitimate. ?de-legitimises trying to form longer interactions
There are no rules to govern this kind of relating	I can relate to people however I want when I'm talking about normal things, because its not a technique or a treatment so I can't get it wrong.	Feels like being friendly, having informal chats. Allows staff personality to emerge.	Having a cup of tea together, shared everyday interactions are OK to do.
Without normal interactions, there is no life.	Criticise senior staff for neglecting the ward atmosphere, allowing it to be lifeless.	The ward is dead, staff are neglectful.	Junior staff and patients must look after themselves. Playing music, having a natter, playing games etc. Anything to bring the ward to life.
<b>Discourse: Person-Centred Discourse</b>			
<b>Discursive Constructs – Stage 2</b>	<b>Action Orientation/function s of constructs – Stage 3</b>	<b>Subject Positions – Stage 4</b>	<b>Practices (stage 5) and ways of understanding (stage 6) made legitimate/illegitimate</b>
Sharing personal experience in response to another's distress	Normalising personal reactions to adverse life events.	Patients' pain and suffering is positioned as understandable. Value of expertise by experience, staff giving of self.	Self-disclosure with a therapeutic aim is legitimised.

A connection based on a comfortable relationship	Allows us to build on the trust we have to do something therapeutically meaningful.	Staff feel trusted, patient can talk about their problems meaningfully.	Staff asking questions about the patient's distress & history, and patient responding honestly & with emotional content.
Can transform the experience of being an inpatient	Relating can actually make people better, it can make or break their time here.	Patient in need of space to talk through their problems with a trusted person. Staff positioned as able to offer this.	Expressing gratitude and appreciation from patient is legitimised. Staff encouraged to feel they were responsible for making a difference.



**Appendix J – Service-Users Participant Information Sheet****[service-user group] Participant Information Sheet.***How do people talk about positive experiences of being with each other while in a mental health inpatient ward, and what difference does it make?*

My name is John Cheetham, and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study I am conducting. Before you decide if you would like to take part, it is important that you understand why the research is being done and what it would involve for you. You can talk to others about this study if you want to.

Why is this study being done, and what am I asking of participants?**What is the purpose of this study?**

This study is looking at the ways staff and service-users on inpatient wards talk about positive interactions with each other and what difference positive interactions make to them. There is a lot of research to suggest that positive relationships between people are very important, but it seems that it can be hard to do this on inpatient wards. I am interested in hearing what makes interactions on wards go well, what can get in the way, and what can influence this process. I hope to contribute to understanding how positive interactions happen on wards, and what difference they make to people's recovery and sense of themselves, as well as to staff's experience of working on a ward.

**Why have I been invited?**

As somebody who has experience of being on an inpatient ward, you are in an excellent position to let me know about your experiences with staff. By sharing your views and experiences, you will be helping me to understand how positive interactions can happen. If you have been a service-user on an inpatient ward in the last 6 months, i.e. discharged from hospital after May/June 2013, then I will not be asking you to take part in this study. This is because it can take several months to settle after an inpatient admission, and might be harder to talk about these experiences after such a short time.

**Do I have to take part?**

Participation is entirely voluntary. If you do take part you will be asked to sign a consent form, and in taking part you are still free to withdraw at any time without giving a reason. This would not affect any care you may receive from the Trust now or in the future, or your involvement in [service-user group].

**What will happen to me if I take part?**

I will be coming to [service-user group] meetings telling people about this study and to answer questions about it. The study has two parts to it, individual interviews and focus groups. You can choose to take part in either or both of these. Individual interviews will take place in a private room at Yeoman House, the building that [service-user group] usually meets in, and I will ask about your experiences of positive interactions with ward staff, what you think about these interactions and what they have meant to you. It is important that you know this is not an audit of the inpatient unit, and I would ask that you try not to use staff members' names when you're telling me about interactions so they also have some anonymity. I will ask for consent to audio-record our conversation, but if you would rather I can write notes whilst we talk instead. The interview would last for between 30 minutes and an hour, and you would be free to end the interview or not answer questions whenever you wanted without telling me why. If you decide to come to the focus group, it will last for about an hour and a half and I will ask similar questions to the individual interviews. I will be audio-recording the group, and will ask for your consent to

record and take part in these groups separately from consent to take part in individual interviews.

**What are the possible disadvantages of taking part?**

Sometimes people find it hard to talk about their experiences openly, and it can be uncomfortable to speak honestly with someone you don't know very well. If you would like to, I can arrange a member of psychology staff to speak with you on the telephone after our interview. I would ask that you think carefully if you want to tell me something difficult. If you do tell me something that leaves me concerned for your safety, or the safety of other people, then I will have to report what has been said to my supervisor, Dr Kate Butt, and follow relevant [NHS Trust] policies and procedures. This would be the only instance where I would breach anonymity. If this does happen, I will inform you beforehand wherever possible. In a consultation meeting with [service-user group], it was agreed that the group could be used by participants to share their experience of the interview and seek support if needed.

**What are the possible benefits of taking part?**

This study will help me to build an understanding of what is helpful about having positive interactions on an inpatient ward, and what can be done to make them more likely to happen. Although I cannot promise that this will directly affect the quality of inpatient services, I hope that the published results of the study will contribute to a larger body of research which could improve the quality of services in the future.

**What if there is a problem?**

Any complaint about the way you are treated or any undue distress you suffer during the study will be addressed. Detailed information about how to make a complaint is in part 2.

**Will my taking part be kept confidential?**

If you decide to take part in this study, I will keep a record of your name and contact details in a password protected Excel file for contact purposes, to which only I will have access. I will not inform anyone else of your decision to either participate in the study or not. I will not disclose what you say to me to anyone other than my supervisors, and this will not be linked with your name unless I have direct concerns about your safety or the safety of other people. Your name and other identifying information will not appear in any reports. Your views will only be reported in an anonymous way and will not personally identify you. Audio-recordings will be stored securely, and will not be shared with anyone. Once I have transcribed the audio-recording, it will be permanently destroyed. I may use some quotes from what you say in my final report, and these will be kept anonymous and/or pseudonymised.

Further information and how to contact me if you are interested in taking part.

**What will happen if I don't want to carry on with the study?**

If you don't want to carry on with the study, you are free to withdraw consent at any time without giving a reason. I would still like to use the information you give me in the interview, but if you feel strongly that you would like it to be removed this can be done and we can discuss this after you leave. Leaving the study will not affect any services you may receive from [NHS Trust] or your involvement in [service-user group].

**Complaints**

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions – see the 'Contact Details' section. If you remain unhappy and wish to complain formally, you can contact Professor Paul Camic, Research Director, Clinical Psychology Training Programme, Canterbury Christ Church University by phoning 03330 117114 or by email at



paul.camic@canterbury.ac.uk.

**Will my taking part in this study be kept confidential?**

The fact of your taking part in this study or not will be kept confidential. The only time I would break this confidentiality would be if I was concerned for your safety, or the safety of others. I will talk through the transcripts of interviews with my supervisors but will retain your anonymity (i.e. I won't share your name or other identifying details). When we meet, I will ask you to complete a brief questionnaire about your background (age, nationality, gender, discipline, if/when you qualified and how long you have worked here), which will be labelled with a number. Only I will know what number you have been given. The digital recording of our conversation will be transferred to a password protected, encrypted memory stick and deleted from the Dictaphone before leaving the building, and only I will have access to it. No identifying information will be attached to this recording. Once the recording has been transcribed, it will be securely deleted. When I transcribe our conversation, I will remove any names of people or places from the transcript, to ensure anonymity.

**Who else will be involved?**

I am also asking staff members from Green Parks House to take part in this study, and will be asking them similar questions to those I ask you. I will not be disclosing any information to them from other interviews, and I will not be asking them questions about you. I will not tell them who has taken part in the study. I will also ask them not to name any service-users in my interviews with them. I will discuss the anonymised and pseudonymised interview and focus group transcripts with both of my supervisors, Dr Kate Butt and Dr Sue Holttum. This is part of the process of insuring that I analyse the data as expertly as possible.

**What will happen to the results of the study?**

This study will be submitted to Canterbury Christ Church University as a part of my doctorate qualification in Clinical Psychology. A copy of the final report will be kept in the Canterbury Christ Church University library. I also plan to publish this study in a national Journal. I may wish to use anonymised quotes from our interview/focus group in these reports, and these will not be associated with any personally identifiable information. When the results of the study are available, I will arrange a meeting with [service-user group] for me to feed back what I have found. I will also provide [service-user group] with a written summary of the findings, so if you would rather not come to the meeting you will still be able to see what the study's findings are.

**Who is organising the funding for the study?**

Canterbury Christ Church University and Surrey and Borders Partnership NHS Trust are both involved in funding my research here.

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Social Care Research Ethics Committee.

**How to contact me about taking part or to find out more**

If you would like to join the study or speak to me to find out more, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me, John Cheetham, and leave a contact number so that I can get back to you. You can also email me on my university account, at jc655@canterbury.ac.uk. If you are unsure if you would like to participate, you can speak to myself or a [service-user group] colleague about it to help you reach a decision.

**Appendix K – Service-Users Interview Consent Form****Centre Number:****Study Number:****Participant Number:**

## CONSENT FORM

Title of Project: **Discourses of connectedness between inpatient staff and service-users.**

Name of Researcher: **Mr John Cheetham**

**Please initial box if you agree**

**I confirm that I have read and understand the information sheet dated May 2013 (version 2) for this study and have had opportunity to consider the information and ask questions that have been answered satisfactorily.**

**I agree to my interview with the researcher being audio-recorded and transcribed.**

**I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.**

**I agree that anonymous quotes from my interview may be used in published reports of this study.**

I agree to take part in the above study.

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Mr John Cheetham

\_\_\_\_\_  
**Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

**Appendix L – Service-Users Focus Group Consent Form****Centre Number:****Study Number:****Participant Number:**

## CONSENT FORM

Title of Project: **Discourses of connectedness between inpatient staff and service-users.**

Name of Researcher: **Mr John Cheetham**

**Please initial box if you agree**

**I confirm that I have read and understand the information sheet dated May 2013 (version 2) for this study and have had opportunity to consider the information and ask questions that have been answered satisfactorily.**

**I agree to the focus group content being audio-recorded and transcribed.**

**I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.**

**I agree that anonymous quotes from the focus group may be used in published reports of this study.**

I agree to take part in the above study.

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Mr John Cheetham

\_\_\_\_\_  
**Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

**Appendix M – Service-Users Background Information Questionnaire****Centre Number:**                      **Study Number:**                      **Participant Number:**Background Information Questionnaire

What is your date of birth?

What is your gender?

What country were you born in?

What is your ethnicity?

Roughly how long have you been using mental health services?

How long ago were you last on an inpatient ward?

How many times have you been on an inpatient ward?

**Once**                      **2 – 5**                      **6 – 8**                      **More than 8 times**

**Appendix N – Staff Participant Information Sheet****Staff Participant Information Sheet**

How do people talk about positive experiences of being with each other while in a mental health inpatient ward, and what difference does it make?

My name is John Cheetham, and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide if you would like to take part, it is important that you understand why the research is being done and what it would involve for you. You can talk to others about this study if you want to.

Why is this study being done, and what am I asking of participants?

**What is the purpose of this study?**

This study is looking at the ways inpatient staff and people who have been service-users on inpatient wards talk about positive interactions with each other, and what difference positive interactions make. There is a lot of research to suggest that positive relationships between people are very important, but that it can be hard to do this on inpatient wards. I am interested in hearing what makes interactions with service-users go well, what can get in the way, and how staff might be able to influence this process. I hope to contribute to understanding how positive interactions happen on wards and what difference they make to people's recovery and sense of themselves, as well as to staff's experience of working on a ward.

**Why have I been invited?**

As a member of inpatient staff, you are in the best position to let me know about your experiences with service-users. By sharing your views and experiences, you will be helping me to understand how positive interactions can happen.

**Do I have to take part?**

Participation is entirely voluntary. If you do take part you will be asked to sign a consent form and in taking part you are still free to withdraw at any time without giving a reason. This will not affect any of your employment rights.

**What will happen to me if I take part?**

I will be coming to the ward to tell people about this study and giving the chance for people to ask me questions about it before conducting the interviews. The study has two parts to it, individual interviews and focus groups. You can choose to take part in either or both of these. Individual interviews will take place in a private room in Green Parks House, where I will ask about your experiences of positive interactions with service-users, what you think about these interactions and what they have meant to you. I would ask that you try not to use people's names when you're telling me about interactions so they also have some anonymity. I will ask for consent to audio-record our conversation, but if you would rather I can write notes whilst we talk instead. The interview would last for between 30 minutes and an hour, and you would be free to end the interview whenever you wanted, or not answer a question without saying why. If you decide to come to the focus group, it will last for about an hour and a half and I will ask similar questions to the individual interviews. I will be audio-recording these groups, and will ask for your consent to record and take part in these groups separately from consent to take part in individual interviews. I will not tell any of your colleagues or your manager if you chose to take part or not.

**What are the possible disadvantages of taking part?**

Sometimes people find it hard to talk about their experiences openly, and it can be uncomfortable to speak honestly with someone you don't know very well. If you would like to, I can arrange a member of psychology staff to speak with you on the

telephone after our interview. I would ask that you think carefully if you want to tell me something difficult. If you do tell me something that leaves me concerned for your safety, or the safety of other people, then I will have to report what has been said to my supervisor, Dr Kate Butt, and follow relevant [NHS Trust] policies and procedures. This would be the only instance where I would breach anonymity. If this does happen, I will inform you beforehand wherever possible. Your employment rights will not be affected by this in any way.

**What are the possible benefits of taking part?**

This study will help me to build an understanding of what is helpful about having positive interactions on an inpatient ward, and what staff need to feel supported in building these interactions. Although I cannot promise that this will directly affect your work environment now, I hope that the published results of the study will contribute to a larger body of research which could improve the quality of services in the future.

**What if there is a problem?**

Any complaint about the way you are treated or any undue distress you suffer during the study will be addressed. Detailed information about how to make a complaint is in part 2.

**Will my taking part be kept confidential?**

If you decide to take part in this study, I will keep a record of your name in a password protected Excel file for contact purposes, to which only I will have access. I will not inform your managers of your decision to either participate in the study or not. I will not disclose what you say to me to anyone other than my supervisors, and this will not be linked with your name unless I have direct concerns about your safety or the safety of other people. Your name and other identifying information will not appear in any reports. Your views will only be reported in an anonymous way and will not personally identify you. Audio-recordings will be stored securely, and will not be shared with anyone. Once I have transcribed the audio-recording, it will be permanently destroyed. I may use some quotes from what you say in my final report, and these will be kept anonymous and/or pseudonymised.

The study in a bit more detail.

**What will happen if I don't want to carry on with the study?**

If you don't want to carry on with the study, you are free to withdraw consent at any time without giving a reason. I would still like to use the information you give me in the interview up until the point you leave the study, but if you feel strongly that you would like it to be removed this can be done and we can discuss this after you leave. Leaving the study will not have any affect on your employment rights.

**Complaints**

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions – see the ‘Contact Details’ section. If you remain unhappy and wish to complain formally, you can contact Professor Paul Camic, Research Director, Clinical Psychology Training Programme, Canterbury Christ Church University by phone on 03330 117114, or by email at [paul.camic@canterbury.ac.uk](mailto:paul.camic@canterbury.ac.uk).

**Will my taking part in this study be kept confidential?**

The fact of your taking part in this study or not will be kept confidential. The only time I would break this confidentiality would be if I was concerned for your safety, or the safety of others. I will talk through the transcripts of interviews with my supervisors but will retain your anonymity (i.e. I won't share your name or other identifying details). When we meet, I will ask you to complete a brief questionnaire

about your background (age, nationality, gender, discipline, if/when you qualified and how long you have worked here), which will be labelled with a number, which will be used for analysis purposes only and will not be linked to your name. The digital recording of our conversation will be transferred to a password protected, encrypted memory stick and deleted from the Dictaphone before leaving the hospital, and only I will have access to it. No identifying information will be attached to this recording. Once the recording has been transcribed, it will be securely deleted. When I transcribe our conversation, I will remove any names of people or places from the transcript, to ensure anonymity.

**Who else will be involved?**

I am also asking members of [London Borough] [service-user group] who have experience of being a service-user on an inpatient ward to take part in this study, and will be asking them similar questions to those I ask you. I will not be exchanging any of your information with them, and I will not be asking them questions about you. I will also ask them not to name staff members in my interviews with them. I will discuss the anonymised interview and focus group notes with both of my supervisors, Dr Kate Butt and Dr Sue Holttum. This is part of the process of insuring that I analyse the data as expertly as possible.

**What will happen to the results of the study?**

This study will be submitted to Canterbury Christ Church University as a part of my doctorate qualification in Clinical Psychology. A copy of the final report will be kept in the Canterbury Christ Church University library. I also plan to publish this study in a national Journal. I may wish to use anonymised quotes from our interview in these reports, and these will not be associated with any personally identifiable information. When the results of the study are available, I will arrange a meeting at Green Parks House for me to feed back what I have found. I will also provide a written summary, which you can access if you would rather not attend this meeting.

**Who is organising the funding for the study?**

Canterbury Christ Church University and Surrey and Borders Partnership NHS Trust are both involved in funding my research here.

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Social Care Research Ethics Committee.

**How to contact me about taking part or to find out more**

If you would like to join the study or speak to me to find out more, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me, John Cheetham, and leave a contact number so that I can get back to you. Alternatively, you can email me at [jc655@canterbury.ac.uk](mailto:jc655@canterbury.ac.uk). If you are unsure if you would like to participate, you can speak to myself or a colleague about it to help you reach a decision.

**Appendix O – Staff Interview Consent Form****Centre Number:****Study Number:****Participant Number:**

## CONSENT FORM

Title of Project: **Discourses of connectedness between inpatient staff and service-users.**

Name of Researcher: **Mr John Cheetham**

**Please initial box if you agree**

**I confirm that I have read and understand the information sheet dated May 2013 (version 2) for this study and have had opportunity to consider the information and ask questions that have been answered satisfactorily.**

**I agree to my interview with the researcher being audio-recorded and transcribed.**

**I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.**

**I agree that anonymous quotes from my interview may be used in published reports of this study.**

I agree to take part in the above study.

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Mr John Cheetham

\_\_\_\_\_  
**Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**



**Appendix P – Staff Focus Group Consent Form**

**Centre Number:**                      **Study Number:**                      **Participant Number:**  
 CONSENT FORM

Title of Project: **Discourses of connectedness between staff and service-users on an inpatient ward.**

Name of Researcher: **Mr John Cheetham**

**Please initial box if you agree**

**I confirm that I have read and understand the information sheet dated May 2013 (version 2) for this study and have had opportunity to consider the information and ask questions that have been answered satisfactorily.**

**I agree to the focus group content being audio-recorded and transcribed.**

**I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.**

**I agree that anonymous quotes from my interview may be used in published reports of this study.**

I agree to take part in the above study.

<b>Name of Participant</b>	<b>Date</b>	<b>Signature</b>
Mr John Cheetham		
<b>Name of Researcher</b>	<b>Date</b>	<b>Signature</b>

**Appendix Q – Staff Background Information Questionnaire****Centre Number:**                      **Study Number:**                      **Participant Number:**Background Information Questionnaire

What is your date of birth?

What is your gender?

What country were you born in?

What is your ethnicity?

What is the name of your profession?

Roughly how long have you been working in this profession?

Have you completed a professional training course to work in this field?

**Yes**                      **No**

If yes, when did you complete your training?

**Appendix R – End of Study Letter to NHS Ethics and R&D****DECLARATION OF THE END OF A STUDY**

(For all studies except clinical trials of investigational medicinal products)

*To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research (“the main REC”) within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.*

**1. Details of Chief Investigator**

Name:	Mr John Cheetham
Address:	C/O Canterbury Christ Church University Salomons Centre for Applied Psychology Runcie Court, Broomhill Lane Southborough, Tunbridge Wells TN3 0TF
Telephone:	03330117073
Email:	jc655@canterbury.ac.uk
Fax:	01892 520888

**2. Details of study**

Full title of study:	A Foucauldian Discourse Analysis of the ways inpatient staff and service-users with prior experience of inpatient services talk about how they relate with each other, and what this means for them.
Research sponsor:	Prof. Paul Camic, Canterbury Christ Church University.
Name of main REC:	Social Care Research Ethics Committee (SCREC)
Main REC reference number:	13/IEC08/0006

**3. Study duration**

Date study commenced:	June 2013
Date study ended:	March 2014
Did this study terminate prematurely?	<i>Yes / <b>No</b></i> <i>If yes please complete sections 4, 5 &amp; 6, if no please go direct to section 7.</i>

**4. Recruitment**

Number of participants recruited

Proposed number of participants to be recruited at the start of the study  
If different, please state the reason or this

**5. Circumstances of early termination**

What is the justification for this early termination?	n/a
---	-----

**6. Temporary halt**

Is this a temporary halt to the study?	<i>Yes / No</i>
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

**7. Potential implications for research participants**

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	n/a
---	-----

**8. Final report on the research**

Is a summary of the final report on the research enclosed with this form?	<i>Yes / No</i> <i>If no, please forward within 12 months of the end of the study.</i>
---	---

**9. Declaration**

Signature of Chief Investigator:	
Print name:	John Cheetham
Date of submission:	17 <sup>th</sup> April 2014

Runcie Court, David Salomons Estate  
Broomhill Road  
Tonbridge Wells  
TN3 0TF  
Email: jc655@canterbury.ac.uk

REC Reference: 13/IEC08/0006

CSP/IRAS Reference: 118163

Dear Sir/Madam,

This letter is to inform you that I have now completed the research project entitled: “discourses of connectedness between inpatient staff and service users”. This project has been written up as a part of my doctoral qualification in Clinical Psychology, and has been submitted to Canterbury Christ Church University (Salomons) for marking.

Please find attached a summary report of my findings from the research project. Should you have any queries about this project or its findings, feel free to contact me using the above details.

Yours faithfully,

Mr John Cheetham  
Trainee Clinical Psychologist

End of Research Summary Report

This research project was a Foucauldian discourse analysis of the ways in which members of staff and ex-inpatients from a psychiatric mental health unit spoke about their experiences of positive interactions with one another. The objectives were to explore how staff and service-users talk about the experience of positively relating to one another, how this way of talking positions people, and how people use these ways of understanding relating to inform the ways they act and speak in social situations, using the 6-step methodology of a Foucauldian Discourse Analysis (Willig, 2008).

Two service-users and three staff members were interviewed, and nine service-users and six staff members partook in focus groups. Conversations were audio-recorded and transcribed by the researcher.

Overall, four discourses were seen in the transcripts. The most dominant discourse was labelled the 'medical-technical-legal discourse'. This was defined by a presence of relating constructed as 'a procedural or instrumental application', 'a way of implementing practical elements of care', 'having utility or functions to assist assessment of mental state and risk', 'an expression of accountability', and 'regulated by a disease model of distress'. This discourse positioned people as either 'passive recipient of medical care' or 'accountable expert'. Those positioned in the domain of passive recipient of medical care were thought of as unstable and untrustworthy, as their illness took over their personality and made them act in bizarre and unpredictable ways. There was an idea that talking or relating was no use when a person was 'acutely unwell', and may only make them worse.

The experience of being related to through this discourse was reacted to negatively by service-users. A reactionary discourse was drawn on, informed by the civil rights movement. This discourse constructed relating as 'an essential and basic right' and 'egalitarianist', which seemed to be withheld by mental health services. Service-user participants constructed their experiences as 'I am treated like second-class citizen', 'staff don't help me understand my problems', and 'even terminally ill patients get more investment'.

Two further discourses were noted as competing with the medical-technical-legal discourse. These were labelled 'person-centred discourse' and 'discourse of ordinary humane relating'.

The 'person-centred discourse' constructed relating as defined by 'emotional openness', 'makes me feel that I matter and am valued', 'an expected way of interacting on inpatient wards', 'not available with staff on inpatient wards', 'sought with other patients', 'an experience of meeting/connecting with someone', 'feeling understood', 'enabling change'. When staff spoke of relating through the person-centred discourse, this kind of relating was constructed as 'hard to achieve', 'easily becomes unprofessional', 'a liability', and 'makes you too sensitive'. In a similar way to the medical-technical-legal discourse, this discourse positions people as in need of care and as capable of providing the care needed; however the actions associated with relating through this discourse were extremely different. These actions included gestures of kindness, emotional openness and responsiveness between staff and service-users, and an expectation from service-users that staff were trained and skilled

in providing these sorts of interactions. This meant that service-users were puzzled, confused and disappointed when relating as constructed under a 'person-centred discourse' was not found to be available on the wards.

The 'discourse of ordinary humane relating' constructed relating as 'ordinary', 'simple', 'intrinsically human', 'learned through every-day life', 'available through chatting', 'allowing personalities to emerge' and 'enhancing trust'. This ordinariness was seen as acutely juxtaposed against the environment of an inpatient ward, strikingly described as 'a snowball in hell that somehow seems to survive'. The inpatient environment was described as intrinsically abnormal, making the need for ordinary kinds of relating viscerally felt. Some staff described this kind of relating as being 'a tonic to socially inherited stigma'. Others described how they did not feel able to relate in an ordinary way on the wards, as they felt a requirement to hide aspects themselves in order to be considered as professional, and doing their duty. Where this discourse was freely acted into, it positioned people as equal, building on a sense of 'oneness' and recognition of human similarities and the gossamer thread between service-user and service-provider. Consequently, a sense of 'all people deserve care' developed, and it almost became possible for roles of 'staff' and 'patient' to be sidelined, and for relating to occur regardless of social status.

I will disseminate the results of this study through publication in the British Psychological Society's journal 'Psychology and Psychotherapy: Theory, Research and Practice', and at a conference organised by the NHS Trust where the research was conducted.

**Appendix S – Journal Author Submission Guidelines****Psychology and Psychotherapy: Theory, Research and Practice**

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Edited By: Andrew Gumley and Matthias Schwannauer

Impact Factor: 1.69

ISI Journal Citation Reports © Ranking: 2012: 44/75 (Psychology); 56/114 (Psychology Clinical); 58/121 (Psychiatry (Social Science)); 79/135 (Psychiatry)

Online ISSN: 2044-8341

**Author Guidelines**

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

**1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

**2. Length**

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.



Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

### 3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

### 4. Submission and reviewing

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