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THE ROLE OF THE ORGANISATIONAL CONTEXT ACROSS THE PSYCHOSIS SERVICE PATHWAY

Section A: Moral distress, a climate of stress and fear and an inability to think:

When the organisational context conflicts with valued practice

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Thank you to all the participants who took the time to share with me their remarkable work, insights, and expertise.

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Summary of the Major Research Project

Section A: Presented here, is a systematic review of literature detailing experiences of mental health professionals where the organisational context represented a challenged to their valued practice. A critical appraisal of the 11 included studies is discussed. The qualitative aspects of studies were synthesised using thematic synthesis. Four major analytic themes emerged. These include ‘Perceptions of organisation: An inability to think’, ‘A climate of stress and fear’, ‘Moral distress’, and ‘Self in relation to the organisation’. Implications for organisational unlearning include the need to promote and facilitate reflective spaces. Recommendations for future research include the need to understand the experiences of those considered to hold the most power in mental health contexts.

Section B: Presented here, is a study exploring the processes used by psychologists, working across the ‘psychosis’ service pathway, to navigate the organisational context and enable the facilitation of meaningful therapeutic interventions (as perceived by them). Guided by a constructivist grounded theory methodology, the constructed model identifies eight interacting categories organised within three domains: ‘Navigating a complex system’, ‘Stepping into authority’, and ‘Influencing change’. Findings emphasise the importance of making spaces to enable connection and collaborative learning, facilitating a shared understanding, and a greater receptivity to psychological positions within these contexts. Implications for clinical practice are discussed.

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ABSTRACT

Introduction: Holding a biomedical understanding of ‘psychosis’ can have considerable social implications for those diagnosed. Despite government policies requiring shifts to recovery-oriented practice, implementation remains variable and contentious. Literature on organisational unlearning suggests that understanding the perspectives of organisational actors may offer new insights into processes of de-implementation, with support for organisational change enhanced when changes are aligned with personal values. This paper sought to critically evaluate and synthesise the literature detailing experiences of clinicians where the organisational context represented a challenge to their valued practice.

Methodology: Systematic searches were conducted using Web of Science, PsychINFO, PsychArticles, ASSIA and MEDLINE databases. Ten qualitative studies and one mixed-method design met eligibility criteria.

Literature review: Thematic synthesis was employed, identifying eleven descriptive themes, and four major analytic themes. These include ‘Perceptions of organisation: An inability to think’, ‘A climate of stress and fear’, ‘Moral distress’, and ‘Self in relation to the organisation’.

Clinical and research implications: Findings indicate that organisational unlearning can be supported through initiatives which promote and facilitate reflection. Further research is needed to understand the position and experience of those considered to hold the most power in these contexts.

Keywords: Psychosis, Grounded Theory, Organisational unlearning, Values

Introduction

‘Severe mental illness’ is a term most frequently applied to conditions which fall under the diagnostic umbrella of ‘psychosis’. A psychosis-related diagnosis is often given when distressing psychological experiences (which can include hearing hostile voices and seeing disturbing visions) significantly impact a person’s social functioning (Ruggieri et al., 2000). Explanations for ‘psychosis’ are hotly debated (Cooke, 2017), often along the lines of biomedical versus social causes. Irrespective of the evidence on biogenetic causality, widely shared understandings of ‘psychosis’ have social consequences, which can themselves increase or reduce the difficulties of those receiving this type of diagnosis. For example, a review by Angermeyer and colleagues (2011) suggests that biogenetic explanations for mental health difficulties are associated with increased public rejection, discrimination, and stigma. Furthermore, maintaining a strongly biogenetic position has consequences for the attitudes of organisations and health care professionals working with people with psychosis-related diagnoses, particularly in relation to expectations for recovery (Hinshaw & Stier, 2008). This introduction first outlines ongoing controversies surrounding ‘psychosis’. Literature concerning the implementation of organisational change is then considered.

‘Psychosis’: A brief history

Gaebel and Zielasek (2015) describe ‘psychosis’ as a diagnostic construct characterised by a number of core observable phenomena, or ‘symptoms’ that often occur together. The experiences in question are said to include different combinations of hallucinations (perceptions not shared by others), delusions (non-consensual or unusual beliefs), disorganised speech, social withdrawal, and loss of motivation. Groupings of particular experiences determine the specific diagnosis given (e.g., ‘schizophrenia’, ‘schizoaffective disorder’, ‘bipolar disorder’). Despite more than a century of research, the causes of the experiences here termed ‘psychosis’ and ‘schizophrenia’ continue to be debated (Cooke, 2017). Considered by some “the ‘prototypical’ psychiatric disease” (Boyle, 2002, p.15; Johnstone, 2011, p. 101), ‘schizophrenia’ (initially termed ‘dementia praecox’) was first introduced as a construct by Emil Kraepelin in 1893.

Kraepelin advocated the view that there were a number of distinct ‘natural disease entities’ each associated with a different brain pathology and symptom picture (Bentall, 2003, p. 13). Based on Kraepelinian ‘disease’ models, modern psychiatry (‘neo-Kraepelinian’) has continued to develop systems of classification to determine diagnosis, prognosis and treatment, a framework often referred to as the ‘medical model’ (Johnstone & Boyle, 2018). The two most prominent classification systems are the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; American Psychiatric Association, APA, 2013) and the International Classification of Diseases, 10th Edition (ICD-10; World Health Organisation, WHO, 1992).

Neo-Kraepelinian classification

Central to the ‘neo-Kraepelinian’ position is that there exists a biological basis (at a genetic, hormonal, neuro-anatomical or neurochemical level) to the distress experienced. Despite considerable research efforts and investments, evidence for distinctive biological mechanisms, however, remain absent (see Boyle, 2002; Cooke, 2017). Diagnostic classification also continues to receive criticism from those self-describing as mental health system survivors (e.g., Dillon, 2011) and from members of the scientific and clinical community. For example, in addition to demonstrations of poor reliability (Read, 2013) and validity (Khoury et al., 2014), a prominent critique levelled at the publication of the DSM has been the system’s encroaching ‘medicalisation of normality’ (Conrad, 2007; Frances, 2010, 2013) and its lack of a scientific basis (Davies, 2013). The dominant assertion that ‘schizophrenia’ and other psychiatric conditions are brain diseases has meant that the content of the distressing experiences are often not considered meaningful or coherent (Jacobs & Cohen, 2010). Arguably, this ignores or gives insufficient attention to the growing body of evidence linking childhood and adult stress and adversity to experiences of ‘psychosis’ and other mental health difficulties (e.g., Bergström et al., 2019; Read et al., 2014; Romme et al., 2009). It means, in effect, that many people who enter the mental health system may be subject to treatments that are based on a poor understanding of their difficulties. The implications of this are considerable.

Individual implications

The framing of distressing, confusing or complex emotional states within a predominantly medical framework brings further implications for the individual. It has been argued, for instance, that biomedical narratives regarding ‘mental illness’, often reflected within and reinforced by the media (Beresford et al., 2010; 2016), can contribute to perceptions of dangerousness, a desire for social distance, and pessimism regarding recovery (Larkings & Brown, 2017). Embedded in a historical fear of ‘madness’, public appraisals of psychosis-related diagnoses as ‘contagious’ persist (Walsh & Foster, 2020). Considerable research has demonstrated that receiving a psychosis-related diagnosis can result in discrimination and stigmatising attitudes both from wider society (Dinos et al., 2004; Read et al., 2006) and from healthcare providers (Knaak et al., 2017). Longden and Read (2017) have argued that locating the underlying cause within the individual continues to exacerbate a ‘them and us’ mentality.

Clear power asymmetries exist between mental health professionals and service users. In the context of the mental health system, *a priori* assumptions regarding psychiatric illness can undermine service-users’ perceived legitimacy as knowers of and contributors to their own experience (Sanati & Kyratsous, 2015; Crichton et al, 2017). Drawing on theories from disability studies, proponents of a social model of distress (Beresford, 2010; 2016) argue that this attribution of impairment is a form of disablement. Reeve (2015) argues for two forms of disablism: structural and psycho-emotional. Operating at a public level, structural disablism refers to the barriers impacting on what people are able to do, whereas psycho-emotional disablism represents restrictions on who a person can be. Arguably, in the continued promulgation of the diagnostic model and through associated professional attitudes, the mental health system operates a form of institutional psycho-emotional disablism (Reeve, 2015).

Alternative understandings

While the term ‘psychosis’ is a diagnostic construction, the experiences that it encompasses are very real. It is also acknowledged that, for some, a biomedical framework may provide a useful way of understanding their experiences (Johnstone, 2014). For others, however, the close relationship between receiving a psychiatric diagnosis and accessing structures designed to provide support (e.g., Equalities Act (2010); welfare system, supported housing) can pose real difficulties for service-users who do not choose to understand their experiences within this frame. Importantly, alternative frames of understanding have, however, been developed. One prominent alternative is offered by the Hearing Voices Movement (HVM; see intervoiceonline.org), an international service-user/survivor organisation which considers experiences such as voice-hearing to be “significant, decipherable and intimately connected to a person’s story” (Dillon, 2013, para. 10), thus requiring that a person be considered within their historical, cultural, relational and socio-political contexts (Higgs, 2019).

Operating predominantly within mental health organisations, the profession of clinical psychology has been increasingly vocal in the need for an alternative psycho-social approach to diagnosis (BPS Division of Clinical Psychology, DCP, 2013). The BPS, for instance, published a report entitled *Understanding Psychosis and Schizophrenia* (Cooke, 2014, 2017). In line with the HVM, this report argues that experiences labelled 'psychotic' can be understood as a reaction to stressful life circumstances such as trauma, abuse or deprivation (Cooke, 2017). This view is supported by a growing body of evidence, much of it summarised by Read and colleagues (2014). The report called for a trauma-informed, 'collaborative formulation' (BPS DCP, 2011, p. 22), an approach which seeks to understand the person within the context of their experience, assuming that "…at some level it all makes sense" (Butler, 1998, p 2). Rather than 'symptoms' indicating an underlying biological illness, the report recognises that 'psychotic' experiences may represent one end of a continuum of human experience (Verdoux & van Os, 2002).

Diagnosis and Race: A projective act

In the application of the scientific method to human experience, the history of both psychiatry and psychology are firmly rooted within the positivist tradition. The implications of this philosophical framework have been discussed in detail elsewhere (see Johnstone & Boyle, 2018). Here, however, it is necessary to address psychiatry's positivist claim to objectivity and value-neutrality (Ingleby, 1981). As detailed by psychiatrist Jonathan Metzl, when applied in practice, diagnosis 'remains a projective act' combining scientific understanding with an entanglement of ideological and political assumptions (Metzl, 2009, p. xvii). In tracing the history of the DSM through a socio-historical lens, Metzl provides a detailed account of how the racialised Black male identity became entwined in the diagnostic construct of 'schizophrenia' at a time of civil protest and social unrest. Implications of this political history continue to be felt, Metzl (2009) argues, because racism, and the racialised history of the 'schizophrenia' construct is embedded within institutions, shaping 'interactions and outcomes long before participants appear on the scene' (Metzl, 2009, p.202). Black communities within the UK face significantly higher rates of compulsory admission (Ahsan, 2020), inequitable treatment (see Fernando, 2017; Bignall et al., 2019) and are more likely to be regarded as difficult to engage (Wagstaff et al., 2018). Metzl (2009, p.191) further argues that the continued logic of focusing on observable characteristics requires a ‘collective forgetting’ of the historical foundations of the frames that govern observation.

Debunked, disabling and still dominant?

Offering a radical shift away from the traditional paradigm of symptom reduction, is the ‘recovery’ approach. Originating within the collectivised knowledge of service user and survivor groups, ‘recovery’ was conceptualised as the recovery of a life ‘post-psychiatric service use’, that is, beyond the associated depersonalisation, passivity, othering and powerlessness (Deegan, 1997). In 2011, the UK policy ‘No Health Without Mental Health’ (HM Government, 2011) was the first to explicitly recognise the objective of personal recovery over symptom reduction (Perkins & Slade, 2012). Required to comply with national policy, organisations have increasingly moved towards implementing recovery-oriented practice (Slade et al., 2014). This requires the adoption of different values (e.g., promoting choice and empowerment) and reconsideration of the dominance of professional expertise over knowledge gained through lived experience (Slade, 2009).

Implementation of the recovery approach remains contentious (Sangiorgi et al., 2019). For some, it represents a challenge to professional training and investment in traditional paradigms. For others, broader organisational changes have served to undermine the capacity of services and staff to implement meaningful changes. Indeed, influenced by political and public agendas, the emergence of recovery-oriented policies coincided with the implementation of a business model within the NHS. These large-scale organisational changes were marked by competitive commissioning, and the implementation of a target driven, cost-saving work design. Wren (2014) describes how these changes resulted in an organisational culture which 'produces insecurity and competition without adequate containment, thereby reducing safety, increasing anxiety and fear and disabling learning' (p.19). Different observers suggest that dissonance remains between policy and practice, with services professing a recovery orientation while maintaining clinical and organisational practices which prioritise symptomatic recovery (Perkins & Slade, 2012; Morera et al, 2017; Jackson-Blott et al., 2019).

Changing organisational practice

Various structures within the NHS may perpetuate medicalised knowledge (i.e., clinical records, policies, procedures, and the overall service architecture), operating together to form an 'organisational memory' (Huber, 1991). In moving away from the paradigm of traditional psychiatry, 'forgetting' or 'unlearning' processes may, therefore, be as important for achieving organisational change as adopting new processes (Solovy, 1999). Organisational unlearning has been broadly defined as the intentional process of discarding organisational knowledge, held for example, in structures, norms, beliefs and values, so as to enable new knowledge to take hold (Klammer and Gueldenberg, 2019). Organisations, in and of themselves, cannot, however, unlearn (Grisold et al., 2020). Instead, it is a process originating at the individual level, which then permeates throughout the team and wider organisation (Zhao et al., 2013). As unlearning appears to entail both behavioural elements (changing routines, processes, and structures) and cognitive elements (altering beliefs, values, and attitudes), psychological research methods which consider the perspective of organisational actors may offer new insights into the recursive relationship between the individual, the team and the organisational unlearning process (Grisold et al., 2020).

Indeed, the importance of the organisational actor's role in driving organisational change has been highlighted within the 'recovery' implementation literature (Farkas et al., 2005). A recent paper by Williams et al. (2016, p. 26) regarded frontline staff as 'the gate keepers of recovery operationalism'. Drawing on research related to self-determination theory (SDT; Ryan and Deci, 2000), Williams posited that the successful adoption of new approaches was determined by the level of autonomy a staff member experiences in relation to the behaviour change (Williams, 2016). In contrast to externally imposed changes, a clinician's motivation to support organisational change is enhanced when they experience high autonomy within the process and perceive the changes as aligned with their personal values (Ryan and Deci, 2000). In moving away from traditional paradigms, clinicians will likely have to navigate a number of value dilemmas related to their perceptions of the role of the mental health system (Taylor & Bentley, 2005).

Rationale

The 'collective forgetting' highlighted through situating the concepts of 'psychosis' and 'schizophrenia' within their socio-historical context is striking given the difficulties experienced with organisational unlearning, and the (in)ability to 'forget' or de-implement practices. Given, as argued above, what appears to be a continued role of mental health institutions in the psycho-emotional disablement of service users, it may be fruitful to examine the literature on the experiences of clinicians, especially where the organisational context is at odds with their valued practice. In recognition of competing obstacles to valued practice, the literature search was not limited to instances where values-based conflicts were specifically related to medicalised approaches to 'psychosis'.

Aim

Developed for qualitative methodology, the modified ‘population, interest, context’ (PICo) framework (Risenberg & Justice, 2014) guided the development of the research question: What is the experience of mental health professionals when the organisational context is at odds with valued practice in relation to people with ‘severe mental illness’?

Method

Search Strategy

Selection of search terms was informed by a preliminary search of the literature. On October 25th 2020, a final systematic electronic search of Web of Science, PsychINFO, PsychArticles, ASSIA and MEDLINE databases was completed. The search strategy required papers to contain within their abstract terms pertaining to ‘organisations’, ‘mental health practitioners’, ‘professional experience’ and ‘severe mental illness’. For a full list of search terms see Appendix A. In recognition of the introduction of a recovery-orientation within governmental policy (HM Government, 2011), date limits were applied from 2011- 2020. Database search retrieved 680 articles initially and reference lists of identified papers were hand searched revealing four additional papers. Figure 1 illustrates each stage of the search process.

Inclusion and exclusion criteria

Studies were included if they examined the experience of mental health practitioners, specifically where it was identified that the dominant context was at odds with their valued practice. Given the exploratory nature of the review question, only findings obtained through interview or focus group and analysed using qualitative methodology were included. Qualitative findings from mixed methods studies were also included. Non-empirical papers were excluded.

Due to limited resources, only studies published in English were included. Full inclusion and exclusion justifications are provided in Appendix B.

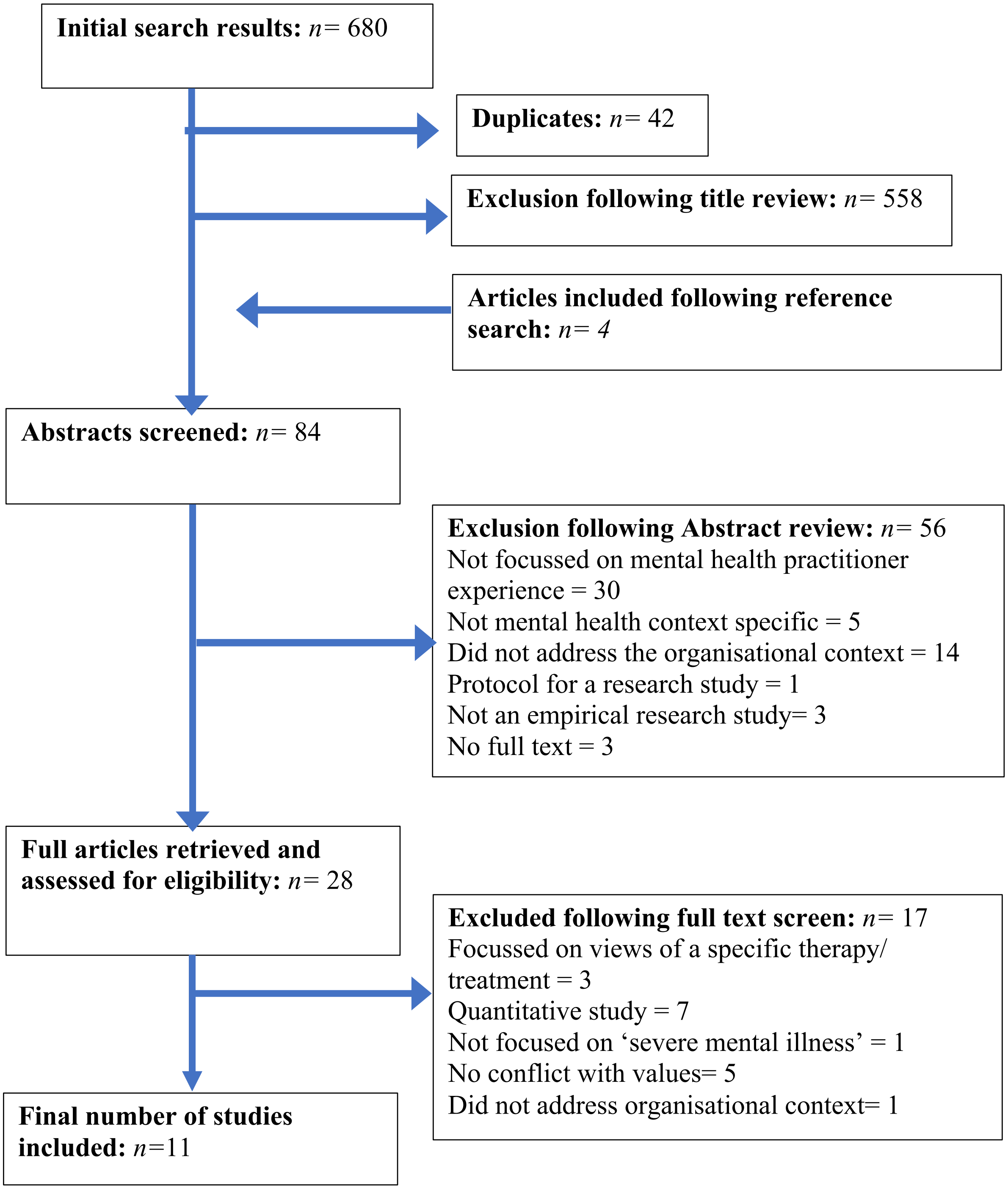

Figure 1.

PRISMA flow chart: Paper selection process.

Structure of review

Eleven studies met eligibility for inclusion in this review. Key information from each study has been summarised and presented in Table 1. Studies have been ordered according to methodology and date. This review will begin by offering a collective description of the eligible studies and a critique of study methodologies with reference to appropriate critical appraisal tools. Synthesised findings are presented using Thematic Synthesis (Thomas & Harden, 2008) and then considered in the context of the wider literature. Finally, clinical implications for service users' experience of care and areas for further research will be considered.

Critical appraisal of studies

Prior to synthesis, the quality appraisal of included studies is an accepted requirement for reviews (Hannes, 2011). Within the qualitative field, there remains little consensus as to what constitutes 'quality' (Denzin, 2009). This review has used the qualitative checklist from the Critical Appraisal Skills Programme (CASP, 2018). The CASP tool is considered a good measure of transparency, emphasising the reported aspects of methodology (Dixon-Woods, 2004). Unmodified, the CASP tool does not, however, enable appraisal of the study's qualitative paradigm (Long et al., 2020), arguably dislocating methods from their interpretative contexts. As such, this review uses an adapted CASP tool developed by Long et al. (2020) which includes the question: 'are the study's theoretical underpinnings (e.g., ontological and epistemological assumptions; guiding theoretical framework(s)) clear, consistent and conceptually coherent?' (See appendix C). Results of the quality appraisal will be used below to guide discussion of the limitations of included studies and provide meaningful context to the various contributions within the synthesis.

Table 1.

Key information from identified literature

Author(s) (Date) and country	Stated aims	Method	Analysis	Setting	Participants	Findings	Key critiques
1. Murphy et al., (2013) UK	To explore clinical psychologists' experiences of working in crisis resolution home treatment teams (CRHTT)	Semi-structured interviews	GT	CRHTT	11 CPs	CPs in this area need to be resilient and flexible- particularly working in a context with a dominant medicalised approach. CPs required to be both separate from and visible within team. Tension exists between reactive vs reflective	No discussion of theoretical saturation in recruitment of participants. Does not explicitly state own perspective, impacting transparency of research actions. Credibility checks not explicated in paper
2. Tickle et al., (2014) UK	To explore the views of clinical psychologists regarding 'risk' and 'recovery' in the context of mental health services	Semi-structured interviews	GT	AMHS specialist, acute and rehab	11 CPs	CPs are aware of recovery-oriented approaches but unable to incorporate them due own limitations and context. CPs discuss a lack of active interaction with the social change process. CPs hold a narrow view of risk.	No discussion of theoretical saturation in recruitment of participants. Does not explicitly state own perspective, impacting transparency of research actions. No consideration of individual service culture on concept of risk.
3. Hanley et al., (2017) UK	To explore the effects of organisational change upon staff working in a Community Mental Health Team (CMHT)	Semi-structured interviews	GT	CMHT	2 CMHN, 1 CPN, 2 CBT, 1 Psyc, 1 SW & 1 CP	Participants felt that organisational changes undermined their professional values and integrity. Bullying and punitive management culture was considered evident. The emergence of a culture of fear and anxiety was reported as detrimental to wellbeing.	Does not state own perspective impacting transparency of research actions. Relationship between researcher and participants not addressed. No discussion of credibility checks

4. Jones et al., (2018) USA	To explore providers values, ideals, current state of services and perceived barriers to improving these services for clients with psychosis.	Focus groups and semi-structured interviews	GT	CMHA	32 Frontline clinicians	Participants emphasized the importance of the therapeutic relationship and the value of engaging with the subjective meaning of clients' beliefs and experiences. Participants identified macrolevel factors that they felt worked against these ideals.	Participants may represent the more skilled providers and/or those most interested in 'psychosis'. Although addresses relationship to participants, does not demonstrate reflexivity regarding potential impact. No discussion of credibility checks
5. Cooke et al., (2019) UK	To explore the challenges faced by clinical psychologists who are critical of the dominant medical model and how they manage them	Semi-structured interviews and focus group	GT	AMHS	19 CPs	Psychologists described discomfort with the medical model, leading to conflict, compromise and collusion. Dominant medicalised discourses felt to impact alternative discussions about distress. Organisational structures protect against anxiety.	Sampling strategy may not reflect the views of all clinical psychologists working in mental health settings. Transparent, reflexive and credible data collection and analysis.
6. Crawford et al., (2013) UK	To explore the language of compassion used by MHP and ways threat stress influences language choices	Semi-structured interviews	Corpus-assisted discourse analysis	Acute MHS	2 CnPsyc, 2 WM, 2 WS, 8 MHN, 1 S-MHN & 5 HCAs	The language indicated Production-line mentality an institutional mentality and emotional distancing between practitioners and patients, despite concern for delivering a quality service	Naturally occurring data preferred in health language research. Small sample size for corpus assisted discourse analysis. Limited use of quotations may undermine confidence in findings
7. Stacey et al., (2016) UK	To examine to what extent decisions about patients' care are perceived to be shared on adult acute mental health wards.	Focus groups	Critical Narrative Analysis	Acute MHS	5 S/U, 6 carers, 8 OTs, 6 Psyc, 7 MHN, 5 PSW, & 9 SW	All groups felt decisions not shared and s/u voice marginalised. However, each group seen to absolve themselves of capacity to take on responsibility of making decisions, enabling participants	Lack of clarity around recruitment strategy of professionals, potential selection bias. Recruitment from one trust, reflecting one organisational culture. Data collected by focus group,

						to maintain a safe place in terms of professional accountability.	potentially suppressing disparities in views
8. Sutton et al., (2016) UK	To explore healthcare professionals' perceptions of the care of patients with 'treatment resistant schizophrenia'.	Semi-structured interviews	IPA	Clozapine clinics	3 pharmacists 3 doctors, & 4 MHN	There was considerable role ambiguity. Role conflict and job satisfaction inhibited team working and prevented staff from identifying the patients' health requirements and care delivery through innovation in skill mix.	Funded by the Royal Pharmaceutical Society. The researcher does not reflect on their relationship to the study or participants. One of the included interviews completed by different researcher, impact not considered
9. Brooks et al., (2017) UK	To explore the care planning and perceptions of its function within MHS from the perspectives of multiple stakeholders.	Semi-structured interviews	Qualitative Framework Analysis	AMHS	10 MHP, 4 S/Us & 3 carers	Care planning characterized by failure to meet the complexity of mental health needs, and processes seen to prioritise organizational agendas and risk prevention	Imbalance between number of recruited professionals, S/U and carers, may mean carer/ SU views are under-represented. No justification for method of analysis. Study is part of a wider RCT, utilising purposive sampling.
10. Ebrahim (2018) UK	To understand how MP-AC can enable clinical leadership and care provision in MHS and explore barriers and enablers to implementation	Semi-structured interviews	Thematic analysis	Adult, young people and ID MHS	3 CPs, 3 MHNs, 3 Psyc	Distributed leadership was still reliant on MHA and framed within a medical model. Participants discussed boundary between therapeutic roles and power in AC role. Helpful to hold patient need at the centre of decision-making.	Small sample size recruited within one organisation. The author has a vested interest in the AC roles being helpful, introducing potential bias in question choice, theme and quote selections. No discussion of researcher's relationship to participants and the impact of this on the research.

11. Wood et al., (2019) UK	To examine adaptations required to deliver psychological therapies to people with psychosis within the acute setting	Semi-structured interviews	Thematic analysis	Acute MHS	6 CP, 2 CoPs, 2 AP, 1 TCP, 1 TCP & CBT	Interventions focused on the current crisis and risk to facilitate discharge. Integration of the patient's social and mental health care system was important. Adaptations were required to deliver psychological therapies in an inpatient environment.	Researcher was a member of the psychology team from which participants were recruited introducing potential bias in data collection and analysis. Small sample size, recruited from one organisation

Note: Aims (CRHTT: Crisis Resolution Home Treatment Teams; CMHT: Community Mental Health Team; MHP: Mental Health Practitioners; MHS: Mental Health Service; MP-AC: Multi-Professional Approved Clinician). Analysis (GT: Grounded Theory; IPA: Interpretive Phenomenological Analysis). Setting (CRHTT: Crisis Resolution Home Treatment Teams; AMHS: Adult Mental Health Service; CMHT: Community Mental Health Team; CMHA: Community Mental Health Agency; MHS: Mental Health Service; ID: Intellectual Disability). Participants (CP: Clinical Psychologist; CMHN: Community Mental Health Nurse; CPN: Community Psychiatric Nurse; CBT: Cognitive Behaviour Therapist; Psyc: Psychiatrist; SW: Social Worker; CnPsyc: Consultant Psychiatrist; WM: Ward Matron, WS: Ward Sister; MHN: Mental Health Nurse; S-MHN: Student Mental Health Nurse; HCA: Healthcare Assistants; S/U: Service Users; OT: Occupational Therapist; PSW: Peer Support Worker; MHP: Mental Health Practitioner; CoP: Counselling Psychologist; AP: Assistant Psychologist; TCP: trainee clinical psychologist). Findings: (CP: Clinical Psychologist; S/U: Service Users; MHA: Mental Health Act; AC: Approved Clinician). Critique (S/U: Service User; RCT: Randomised Controlled Trial; AC: Approved Clinician) Critiques based on modified CASP reviews guidelines (see appendix C)

Results

Overview of studies

Of the eleven studies that met criteria for inclusion, one was from America (Table 1), with the other ten based in the UK. Studies varied in the method of data analysis, with five using grounded theory (GT) one using corpus-assisted discourse analysis (C-DA), one using critical narrative analysis (CNA), one selecting interpretative phenomenological analysis (IPA), one utilising qualitative framework analysis (QAF) and two papers selecting thematic analysis (TA). Eight studies gathered data using semi-structured interviews, one used focus groups and two used both focus groups and semi-structured interviews. The C-DA study is described as a mixed design incorporating an initial word frequency analysis to guide discourse analysis. The qualitative aspects of this study are included in this review.

The aims of the included studies varied and have been summarised in Table 1. It was not always clear from paper titles or stated aims where conflicts occurred as these emerged in study findings rather than being specified *a priori.* All studies did however examine the experiences of mental health practitioners and include reference to where the organisational context is at odds with their valued practice. To variable extents, values conflicts in eight of the studies concerned either a medicalised approach to ‘psychosis’ (Murphy et al., 2013; Cooke et al., 2019; Wood et al., 2019) or difficulties with paternalistic approaches which overlook or fail to make sense of distress (Tickle et al., 2014; Jones et al., 2018; Crawford et al., 2013; Stacey et al., 2016; Ebrahim, 2018). Different mental health contexts are represented in the review, including acute mental health services, specialist clinics, community-based adult mental health teams, rehabilitation and crisis services. In total, the experiences of 195 participants were explored across the studies and a range of mental health practitioners were included. For instance, some studies focused solely on the views of psychological practitioners, while others included multiple members of the multi-disciplinary team. Two studies focused on the experiences of medically oriented staff (Crawford et al., 2013; Sutton et al., 2016) and two additionally included experiences of service users and carers in their research (Brooks et al. 2017; Stacy et al., 2016).

General critique of studies

A summary of the outcome of the modified CASP appraisal is provided in appendix D. Key methodological issues are discussed below.

Design

Of the eleven studies, two lacked either clarity or justification regarding choice of research design (Brooks et al., 2017; Ebrahim, 2018). For example, Ebrahim (2018) identified a 'case-study methodology', however, did not provide the descriptive depth that this methodology requires when discussing the multiple participants interviewed. Brooks et al. (2017) do not state their method of qualitative analysis. Omission of this information limits the ability to offer considered critique of the methodology and subsequent findings.

Theoretical underpinnings

Across the GT studies, one failed to articulate the theoretical underpinnings guiding their research (Murphy et al., 2013), although does reference Charmaz (2003) when introducing GT. This requires the reader to have prior knowledge of the nuances regarding GT approaches. Jones et al. (2018) specify use of a constructivist approach, although this appears incongruent with reported methods of data collection (discussed below). Given that 'methodological self-consciousness' is recognised as a marker of credibility within GT (Charmaz, 2006), contributions from these authors should be considered with caution.

Sampling

According to CASP criteria, the recruitment strategies across all but one paper (Wood et al., 2019) were appropriate to address the research aims. Wood et al. (2019) do not provide explanation as to why participants were selected and appear to have utilised convenience sampling which is 'neither strategic nor purposeful' (Patton, 2014, p.467). Arguably, all studies recruited appropriately located, information-rich participants, however, explicit discussion of the sampling approach was lacking across included studies, failing to convey a theoretically driven approach. Of the studies that do specify their sampling strategy, further clarity is required. For example, Stacey et al. (2016) specify a theoretical sampling approach, but lack the detail required to assess if this is a fair representation. Brooks et al. (2017) state the use of purposive sampling, but this term requires further definition due to the recognised potential for ambiguity (Gentles et al., 2015). Sampling is of particular relevance to GT studies as theoretical sampling is a defining and necessary part of the method (Gentles & Vilches, 2017). Of the five GT studies reviewed, only Cooke et al. (2019) discussed theoretical sampling. In their reporting, the other four GT studies (Murphy et al., 2013; Tickle et al., 2014; Hanley et al., 2017; and Jones et al., 2018) appear to have made *a priori* sampling decisions.

Data collection and analysis

According to CASP criteria, two GT studies (Murphy et al., 2013; Tickle et al., 2014) lacked detail regarding their methods of data collection. A particular critique of both is their lack of attention to theoretical saturation, a criticism also applicable to Jones et al. (2018). Given the iterative relationship in GT between recruitment and analysis (Morse & Niehaus, 2009), transparency regarding saturation is required to enable appraisal of conceptual depth. Five studies lacked detail regarding their reporting of data analysis (Tickle et al., 2014; Jones et al., 2018; Crawford et al., 2013; Sutton et al., 2016; Ebrahim, 2018), although this may reflect non-study related concerns, such as strict word limits (Sandelowski & Barroso, 2002). It does, however, raise concerns about whether analysis was sufficiently rigorous.

There were variations across included studies regarding reflexivity. Two GT studies (Murphy et al., 2013; Tickle et al., 2014) stated that reflexivity had been considered without explaining what was considered and how this may have influenced analysis and data selection. Five other studies (Hanley et al., 2017; Jones et al., 2018; Crawford et al., 2013; Sutton et al., 2016; Brooks et al., 2017) failed to include any discussion of reflexivity. This lack of transparency regarding researcher reflexivity is a significant weakness and fails to consider the influence of the researcher's theoretical orientation and personal biases.

Summary

Overall, despite the shortcomings described above, appraised studies were appropriately designed to address clear research aims and offered valuable research contributions. Across all studies, findings were grounded in participant accounts through use of quotations, enabling a resonance with participant experience. Reader confidence in study findings is strengthened in those where authors have critically examined their own role in the research process (e.g., Cooke et al., 2019; Stacey et al., 2016; Ebrahim, 2018 & Wood et al., 2019).

Data Synthesis

In line with previous studies addressing multidisciplinary experiences (Thomas et al., 2012; Henderson et al., 2020), thematic synthesis (Thomas & Harden, 2008) was employed to enable the translation of reported findings across disparate studies (Thomas et al., 2012). All papers were read multiple times to ensure familiarity with the material. This review then followed the three-stage process detailed by Thomas and Harden (2008). Firstly, results sections of all included studies were coded line-by-line, identifying underpinning themes and concepts. Text was selected if it was considered to represent mental health practitioner experiences of when the organisational context is at odds with their valued practice. A single word (i.e., ‘resistance’) or short phrase (i.e., ‘This is not how I think’) was then used to summarise the identified text. Across the 11 papers, 85 initial codes were developed. Secondly, these codes were then organised into 11 higher level descriptive themes based on conceptual similarities. Finally, four analytical themes were developed, ‘going beyond’ the findings of the original studies (Thomas & Harden, 2008).

Reflexivity

This review has been completed by a trainee clinical psychologist who is critical of the medical model and has experienced different ways in which the organisational context has served to maintain traditional paradigms. The reader is therefore invited to take the author’s position into account in evaluating the interpretations presented. Reflexive notes were made throughout the research process which allowed identification of potential biases and helped maximise fidelity to the included studies.

Table 2.
Major analytic and descriptive themes

Major analytical themes	Descriptive themes
An inability to think	Bureaucratic rather than meaningful Entrenched hierarchical culture Not enough time to think
A climate of stress and fear	Pressure from multiple agendas A hostile environment Threat to traditional role
Moral distress	Discomfort at the domination of the medical model Left feeling guilty Feeling unsafe
Self in relation to the organisation	Distancing self from the mechanics of the organisation Identifying with the organisation Changing from within

Findings

The findings from this synthesis describe multifarious perceptions and experiences of mental health practitioners where their experience of the organisational context conflicted with their valued practice. Eleven descriptive themes were identified from the analysis (see table 2) and four main analytic themes were generated: (a) Perceptions of organisation: An inability to think, (b) A climate of stress and fear, (c) Moral distress, and (d) Self in relation to the organisation. Each analytic theme will be discussed in turn alongside the descriptive themes they comprise. Table 3 details each theme from the interpretive synthesis and the contribution of each study.

Table 3.
Analytic and descriptive themes with study contributions

	Perceptions of organisation: An inability to think			A climate of stress and fear			Moral distress			Self in relation to the organisation		
	Bureaucratic rather than meaningful	Entrenched hierarchical culture	Not enough time to think	Pressure from multiple agendas	A hostile environment	Threat to traditional role	Discomfort at the domination medical model	Left feeling guilty	Feeling unsafe	Distancing self from the mechanics of the organisation	Identifying with the organisation	Changing from within
Murphy et al. (2013)			X			X					X	X
Tickle et al. (2014)	X	X		X	X				X	X		
Hanley et al. (2017)	X				X	X		X		X		X
Jones et al. (2018)		X				X						X
Cooke et al. (2019)		X		X			X	X	X	X	X	X
Crawford et al. (2013)	X	X	X		X							

Stacey et al. (2016)		X					X		
Sutton et al. (2019)		X			X				
Brooks et al. (2017)	X			X					
Ebrahim (2018)						X		X	X
Wood et al. (2019)			X	X			X	X	X

Perceptions of the organisation: An inability to think

This analytic theme was informed by three of the eleven descriptive themes: ‘Bureaucratic rather than meaningful’, ‘Not enough time to think’, and ‘Entrenched hierarchical culture’. The perception that the organisation impacted on the ability to think manifested in various ways.

Bureaucratic rather than meaningful. Practitioners across four studies spoke of how care had become reduced to processes, creating a ‘production-line mentality’. One practitioner stated*: “Sometimes, you just feel like you are getting on with it like a robot…”* (Hanley et al., 2017, p.183). Another stated: *“…there was a focus during appointments on agendas prioritised by the organisation, such as risk assessments, rather than working on longer term recovery goals”* (Brooks et al., 2017, p. 602). These studies suggest that processes of bureaucratisation within the organisation can negatively impact upon the professional’s ability to think meaningfully with the service user about the care they provide.

Entrenched hierarchical culture. Six studies described a hierarchical and paternalistic culture which professionals felt was deeply embedded and impacted on their ability to question prevailing practices. One participant stated: *"It (dissenting) was really difficult, and it used to make me feel… like, oh you silly girl you stepped out of line, why don't you just keep your head down…"* (Cooke et al., 2019, p.205). One study further described the language use of participants as reflecting an 'institutional mentality' (Crawford et al., 2013, p.721) where *"care was from professionals to patients in a top-down way"* (Ibid, p. 724). Here, it appeared that the entrenched attitudes and beliefs of the organisation were constricting the ability to think or act differently.

Not enough time to think. Four studies discussed lacking the time to think. For some this was discussed in relation to patient care, for example, one practitioner stated *"…people don't have the time to think about what they are saying to people, and how they are saying things, and things like that, and that can be a problem"* (Crawford et al., 2013, p. 724). For others, the organisational context was felt to constrain the ability to offer reflective space, which has implications for professional groups where this is considered part of their role. For example, one psychologist stated: *"It doesn't fit really trying to be a psychologist in a team that doesn't want to think" (*Murphy et al., 2013, p.188). Making time to think about themselves in relation to their work was therefore valued.

A climate of stress and fear

Comprised of three descriptive themes: (a) pressure from multiple agendas, (b) a hostile environment, and (c) threats to traditional role, the second analytic theme captures mental health practitioners' perceptions of the organisational environment.

Pressure from multiple agendas. Practitioners across four studies discussed how the pressure from negotiating multiple stakeholders and competing organisational demands can be detrimental to the quality of care delivered. In discussing governmental targets, one practitioner stated: *"the pressure actually pushes us towards rushing it really… rather than taking our time in the care planning process"* (Brooks et al., 2017, p. 601). Other papers discussed the role of external pressures as providing barriers to more valued practices, for example, one practitioner stated: "*The (Government) Department of Health are asking for targets in terms of diagnosis, there are a lot of external pressures… to… use that way of thinking about people…"* (Cooke et al., 2019, p. 204). Another paper highlighted that while some aspects of the organisation may be motivated to embrace recovery approaches, for example, by embracing positive risk-taking, "*the delay in doing so might be underpinned by awareness of a culture of increased accountability and blame"* (Tickle et al., 2014, p. 105).

A hostile environment. The impact of working within a 'culture of blame and litigation' was discussed by practitioners in two studies. When discussing the feeling on the ward, one practitioner stated: *"they [nurses] are very concerned about safety, about criticism, about, er, you know, being held unduly responsible, so I think that's a, a real fear"* (Crawford et al., 2014, p.724). A second paper also highlighted the additional role of competition in creating a hostile environment and how the fear from constant organisational change impacts practice: "*the uncertainty and fear for their jobs, losing your position or being down-banded… everyone tends to, understandably, recoil into that selfishness, look after number one…"* (Hanley et al., 2017, p.188).

Threats to traditional roles. Four studies highlighted how the adoption of a business model within the NHS had undermined professional identities, creating *"agents of austerity,* *enforcing cuts and a harsher regime"* (Hanley et al., 2017, p. 183). One participant stated: "*It's a threat to your professional integrity and that's devastating*" (Ibid, p.183). Another study suggested that contemporary role changes resulted in 'role ambiguity'. Referring to roles in a clozapine clinic, one doctor stated: "*…I suppose in this day 'n' age where you are blurring the boundaries between who can do that it is difficult to say, you know you just need people in those roles"* (Sutton et al., 2016, p.349). These threats therefore impact on valued professional identities.

Moral distress.

The third analytical theme entitled 'moral distress' comprises three descriptive themes: (a) discomfort at the domination of the medical model, (b) left feeling guilty, and (c) feeling unsafe. The term moral distress is used to describe the psychological distress experienced when individuals are not able to act according to their values (Morley et al., 2017).

Discomfort at the domination of the medical model. Two studies made reference to discomfort caused when operating in a system not aligned with one's values. One participant stated: "*you can sometimes end up feeling angry and annoyed with constantly coming up against the medical model when really- that's not how I think or how I am paid to think…"* (Cooke et al., 2019, p.204). Another practitioner highlighted the misalignment between the power afforded by the dominant model and their professional identity: "*The power [as an Approved Clinician] over somebody else's freedom and rights… is an anathema to my role as a psychotherapist*" (Ebrahim, 2018., p.70).

Left feeling guilty. Two studies considered the feelings of guilt experienced by practitioners. In discussing the inability to provide the care that they feel their clients need, one participant stated: "*…so I find myself saying 'sorry I can't, we can't give you any more [therapy* *sessions] than that'…"* (Hanley et al., 2017, p. 183). One practitioner explained "*I think it's quite easy to get caught up in quite a lot of guilt about it…"* (Cooke et al., 2019 p.206) when unintentionally 'colluding' with a model that is not in line with their valued practice.

Feeling unsafe. Two studies discussed the need for practitioner protection. One study discussed this in terms of feeling unsafe within the culture of blame and the need for both themselves and their service users to 'feel safe' to enable recovery (Tickle et al., 2014, p.103). In discussing the possible reasons as to why the medical model remains dominant, another study posited that it functions to protect practitioners from emotional exhaustion: *"If you start to really listen to people's distress and… to what it means, then it is just horrible. (…) It's just so much easier to say, wow you're just psychotic, take some more pills"* (Cooke et al., 2019, p.205). While distinct, these two examples show how traditional paradigms are maintained through a lack of organisational support structures. In both, the practitioners' safety needs are put in competition with the needs of service users. Arguably, moral distress is created as individual practitioners are aware of how practice could be better, but do not perceive themselves to be in a position to make real change.

Self in relation to the organisation

The final analytical theme considers how practitioners position themselves in relation to the organisational system and is comprises three descriptive themes: (a) distancing self from the organisation, (b) identifying with the organisation, and (c) changing from within.

Distancing oneself from the organisation. Five studies discuss how different professional groups may distance themselves from the organisational system. In four studies, practitioners report aligning themselves with service users in terms of power within the organisational hierarchy, for example, one OT stated: "*We fit with the patient, don't we?"*

(Stacey et al., 2016, p. 37). Others considered the parallels between their own experience and their clients: *"I don't feel listened to, so I know what it feels like to be not listened to… I identify with the clients in that way"* (Cooke et al., 2019, p.206). Two studies reported that practitioners distanced themselves from the "*ideologies and processes that they do not agree with" (*Stacey et al., 2016, p. 38), a case of "*…don't shoot the messenger"* (Hanley et al., 2017, p.183).

Identifying with the organisation. Four studies discussed ways in which practitioners identify with the organisational system. Some practitioners identified with a common shared purpose: *"Although there is a hierarchy within the team, all voices are heard. We have the same intention to help the client to recover"* (Murphy et al., 2013, p.189). Some discuss their acceptance of the medical model, working creatively alongside (Wood et al., 2019, p.2053). For others, there was a recognition of the importance of holding positions of authority within the organisational hierarchy as this offered a legitimacy to their views, for example: "*...people understood then that I had the power and therefore just deferred to me"* (Ebrahim, 2018, p. 71).

Changing from within. Six studies considered ways practitioners offer change from within the system. Practitioners across the included studies discussed the importance of relationships within teams, for example, "*how the softer relational power is vital to enable culture change"* (Ebrahim, 2018, p. 71), as well as the need to find "*allies in the team"* (Murphy et al., 2013, p. 189). There was recognition of the need to counter old attitudes, for example, *"We also have to undo a lot of past learning that has led to an entrenched belief in chronic disability"* (Jones et al., 2018, p. 5), and to keep the person at the centre of their work: *"...there's more than just a diagnosis or label or somebody who needs to be medicated. Something about them being a real human being"* (Wood et al., 2019, p. 2053). Some practitioners recognised how *"diagnostic labels… are often used pejoratively and dismissively*" (Cooke et al., 2019, p. 204), and there were multiple examples of how practitioners viewed their role as supporting the team to make sense of service users' experiences. For example, "*…it's not just their risk behaviour, people don't just stab themselves, there's good reasons for it and it's trying to understand that"* (Wood et al., 2019, p.2052) and "*I… just try… my best to describe… what this person is experiencing using the words they use"* (Cooke et al., 2019, p. 207).

Discussion

The aim of this synthesis was to draw out practitioners' experiences of when the organisational context appeared in conflict with preferred and valued practice. As a relatively underexplored area, just 11 papers met criteria for inclusion. Despite not limiting papers to where the medicalised approach to 'severe mental illness' was a feature of values conflict, three of the included studies explicitly made reference to this (Murphy et al., 2013; Cooke et al., 2019; Wood et al., 2019), with five referring to difficulties with 'paternalistic' models of care that over-looked distress or meaning making (Tickle et al., 2014; Jones et al., 2018; Crawford et al., 2013; Stacey et al., 2016; Ebrahim, 2018). Other papers focussed more on value conflicts due to bureaucracy or changes in work design (Hanley et al., 2016; Sutton et al., 2016; Brooks et al., 2017). This suggests that the issues highlighted within the introduction are salient for practitioners across contexts. Throughout the synthesis a particularly striking finding was the multiple ways in which participants experienced the organisational context as contributing to an 'inability to think'. Limited time and increased organisational processes impacted ability to provide thoughtful care, leading to 'thoughtless' interactions both with service users and within teams. Furthermore, the entrenched hierarchical nature of mental health services appeared to limit the perceived autonomy of practitioners in offering new ways of thinking. These findings are aligned with the observations by Wren (2014), wherein uncontained organisational changes can lead to a culture of increased anxiety and reduced psychological safety thereby disabling learning.

The analytic category, ‘A climate of stress and fear’, captures practitioners’ shared perceptions of the organisational climate (Hemmelgarn et al., 2006). The descriptive themes highlight a culture of demand, blame, and insecurity. This analytic theme highlighted multiple implications for service users, for example, rushed care (Brooks et al., 2017, p.601) and being reduced to a diagnosis (Cooke et al., 2019, p.204). Multiple implications were further highlighted for staff, such as a perceived reduction in their ability to embrace recovery approaches (Tickle et al., 2014, p.105) and a need to protect themselves (Hanley et al., 2017, p.188).

The analytic theme, ‘Moral distress’, describes the emotions experienced when individuals are not able to act according to their values (Morley et al., 2017), arguably capturing practitioners’ psychologic climate (James & James, 1989). Practitioners across multiple studies used terms such as ‘discomfort’, ‘anger’, ‘annoyance’, ‘frustration’, and ‘guilt’, revealing a number of threat responses. Uncontained, these emotional responses may have implications for staff wellbeing, organisational commitment, and role satisfaction (Hemmelgarn, et al., 2016). Practitioners also spoke of the need for safety. Here, the lack of organisational containment can be seen to position the safety needs of practitioners against those of service users. Building on the work of Menzies-Lyth (1988), one paper (Cooke et al., 2019) hypothesised that deferring to the ‘medical model’ serves to protect practitioners from emotional exhaustion. Arguably, however, this disengagement from distress risks practitioners detaching from emotions necessary to cultivate compassionate relationships (Wren, 2014). In the context of people with psychosis-related diagnoses, this demonstrates how a lack of organisational containment may support the maintenance of treatments based on a poor understanding of individuals' difficulties, as well as produce uncompassionate attitudes among staff. This is an important implication for services.

The final analytical theme considers how practitioners position themselves in relation to the organisation when experiencing a conflict in values. Practitioners' responses broadly fell within the categories of 'distancing from', and 'identifying with'. Obholzer and Roberts (1994) have argued that working within organisational cultures which produce insecurity and anxiety can lead to the creation of defences (distancing the self from what is difficult) or a quest to find meaning. Practitioners across the different papers appeared to manage these anxieties through different attachments. For instance, attachments to like-minded colleagues (*"finding allies"*; Murphy et al., 2013, p.189), to the organisational hierarchy (*"…I had the power…"*; Ebrahim, 2018, p.71), or to service users ("*We fit with the patient…";* Stacey et al., 2016, p.38). Attachments such as these can occur when the organisation lacks adequate containment. While such attachments may alleviate anxiety, they can serve to increase ambivalence towards the organisation (Wren, 2014) and, by extension, negatively impact on individual commitment to organisational change and unlearning (Grisold et al., 2020).

In emphasising basic psychological needs of autonomy, competence, and relatedness, self-determination theory (Ryan & Deci, 2000) offers a useful lens to consider motivation in relation to supporting organisational change. As discussed above, the need for relatedness is particularly important at times of stress, and the choice of attachment has implications for the capacity to invest in organisational change. Competence, or perceived mastery over the environment, will likely be impacted by factors such as externally imposed targets or a practitioner's hierarchical position (Deci et al., 1999). In addition, increased demand and limited resources likely contribute to a lower sense of autonomy regarding organisational change. Given the importance of the organisational actor's role in driving broader organisational change and unlearning (Grisold et al., 2020), it will likely be necessary to implement organisational initiatives which aim to meet these psychological needs.

The final descriptive theme, 'changing from within', captured a range of approaches used by practitioners when the context was at odds with their valued practice. It was notable that these responses largely came from studies exploring the perspectives of psychological practitioners. These practitioners articulated that they perceived that the purpose of their role was to draw on "relational power" (Ebrahim, 2018. P. 71), to facilitate thinking within the team, and to support "sense making" (e.g., Wood et al., 2019, p. 2052). There was also recognition of the need to counter old attitudes, both in terms of beliefs regarding chronic disability (Jones et al., 2018, p. 5) and the impact of diagnostic shorthand. Many of these strategies promote reflection and containment, identified above as useful in creating conditions for healthy organisational change.

Strengths and limitations

A particular strength of this review is the systematic approach to data extraction, critical appraisal, and narrative synthesis, thereby increasing the robustness of findings (Thomas & Harden, 2008). In exploring practitioners' experiences when the organisational context is in conflict with valued practice, this review synthesised multiple professional viewpoints from various mental health service contexts. A limitation of the review, however, is the lack of attention to the demographics of individual practitioners included. Despite selection of a modified CASP tool, this checklist does not require appraisal as to whether participants' demographic information (e.g., age, gender, ethnicity, socio-economic background) is adequately reported. For example, just two of the studies (Jones et al., 2018; Wood et al., 2019) reported practitioners' ethnicity. Although Metzl (2009) describes a 'collective forgetting of the historical foundations' of the mental health system, different ethnic groups may be more or less aware of these foundations and their consequences. Given that the review was exploring experiences where the mental health service context conflicts with practitioners' values, arguably inadequate representation across the studies could restrict the range of themes that emerged from the synthesis.

It is important to acknowledge the potential influence of the author's position in relation to the medical model on the final synthesis. Underpinning this review was an explicit position that there is a need for a paradigm change, and thus understanding the individual barriers to supporting and facilitating organisational change is critical. A reflective research journal was used throughout in order to minimise the potential for individual assumptions to influence the thematic synthesis. A particular dilemma encountered, for example, related to the paper by Sutton et al., (2016). This included a number of practitioner quotes that, while not demonstrating a values conflict for the participant (and therefore not included in the synthesis), did not fit with the values of this author. For example, 'NHS patients with mental health conditions should not be making complaints' (Sutton et al., 2016, p. 347). This was regarded as evidence of a 'deep structure' in the NHS (Sutton et al., 2016, p. 349).

Clinical implications

Although this review did not select papers focusing on recovery-oriented practice, it was nonetheless relevant in most studies. The review recognises that when it comes to the adoption of recovery-oriented approaches, there remains a discord between policy and practice. Given that both organisational change and unlearning originate at the individual level (Zhao et al., 2013), practitioners' experience of relatedness, competence, and autonomy are important to consider.

Consistent with the organisational literature, the findings of this review recognised how considered and compassionate work design is fundamental to ensuring quality care (Clegg et al., 2014). In particular, it seems important for services to find ways to enable thinking. Services will need to provide and promote the value of reflective spaces, specifically changing behavioural elements of the work design. This will ensure that attention is consciously paid to the form and content of the work, thus attending to the cognitive elements of organisational unlearning (i.e., beliefs, values and attitudes). The cultivation of a reflective culture within services will also enable engagement with the emotional impact of the work, thereby offering containment of anxiety and enhancing the delivery of compassionate care (Wren, 2014).

Research implications

This review was explorative in its aim and succeeded in summarising a range of experiences that arose when the organisational context was at odds with practitioner's valued practice. However, given the limited number of papers appropriate for inclusion, there remains a need for more research in this area. Importantly, despite the inclusion of several service contexts, specialist services such as Early Intervention (EI) were not included in this review. EI services arguably align with a non-diagnostic, preventative philosophy (Corsico et al., 2017), which has implications for the applicability of the review findings to all 'psychosis' services. For many individuals, EI services form a part of the initial journey across the mental health service pathway. Further research is required which considers whether EI services adhere to this philosophy in practice, and, if so, what organisational facilitators have enabled this.

Within this review two approximate patterns of responses emerged. Some practitioners focussed on the conflict in values due to the experience of competing paradigms (e.g., psycho-social vs. medical model), whereas others focussed on conflict in values due to bureaucracy or changes in work design (e.g., meaningful care vs. bureaucratic processes). This likely reflects a number of factors, including the range of professional groups included in the review. If it is accepted that organisational change is required to ensure compassionate services which privilege the service user experience, then future studies would benefit from narrowing the focus to different practitioners' experience of medicalised approaches, including those of psychiatrists, thus allowing more focussed consideration of the enablers and barriers of organisational unlearning.

Conclusion

This review began by providing an argument for alternative ways of understanding experiences, collectively described within services as 'psychosis'. When looking at the reasons why traditional paradigms remain dominant, a number of organisational factors appeared pertinent. These included the move to competitive commissioning models, cost-saving initiatives, and increased focussed on organisationally defined outcomes, which have potentially served to further entrench a medicalised diagnosis-based system. This review synthesised literature which captured practitioners' perceptions of when the organisational context represented a challenge to their valued practice. The synthesis highlighted how the organisational context can be experienced as creating an 'inability to think', 'a climate of stress and fear', and 'moral distress' requiring a positioning of the 'self in relation to the organisation'. Drawing on research related to self-determination theory, this review then considered how, at the individual level, organisational unlearning can be supported through organisational initiatives which promote and facilitate reflection. However, further research is needed, perhaps specifically to understand the position and experience of those normally seen as most powerful, namely psychiatrists.

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Major Research Project: Section B

Psychologists, Psychosis, and the Organisational Context:
A Grounded Theory.

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Abstract

Objectives: The objective of this research was to explore how psychologists understand, negotiate, and adapt to the organisational context in order to facilitate meaningful therapeutic interventions with people with psychosis-related diagnoses.

Design: This study utilised a systematic, qualitative, interview-based design, guided by constructivist grounded theory (CGT).

Methods: 14 psychologists working across the 'psychosis' service pathway participated in semi-structured interviews. Interview transcripts were analysed following CGT guidelines.

Results: Highlighting the complexity inherent in these systems, the constructed model identifies eight interacting categories organised within three domains: 'Navigating a complex system', 'Stepping into authority', and 'Influencing change'.

Conclusions: This study explored processes used by psychologists to promote a psychological understanding of 'psychosis' within a predominantly medical system. Findings emphasise the importance of making spaces to enable connection and collaborative learning, in order to facilitate a greater receptivity to psychological positions within these contexts. Greater attention to the above 'attractors' for change is consistent with the literature on complex adaptive systems. The resulting model therefore may help clinical psychologists in their thinking about the workplace context and where there may be opportunities for influence

Key words: Organisational context, Psychologists, Psychosis, Grounded Theory, Complexity

Introduction

‘Psychosis’ is a diagnostic construct comprising a number of experiences which represent ‘significant alterations to a person’s perceptions, thoughts, moods and behaviour’ (National Institute for Health and Care Excellence; NICE, 2014). Different groupings of these experiences form the basis for different diagnoses, the most common of which is ‘schizophrenia’. Across the literature, debate persists as to how best to describe and understand these experiences (Cooke, 2017). Diagnostic classification, however, continues to impact and shape mental health provision in the UK (Harper, 2013). Traditionally, ‘schizophrenia’ has been regarded as a “diagnosis with an unfavourable course” (Slade et al., 2008). While contested (Cooke, 2017), proponents have continued to characterise ‘schizophrenia’ as ‘devastating’ (e.g., Roffman, 2019; Sullivan et al., 2015). This position has consequences for the attitudes of organisations and health care professionals working with people with psychosis-related diagnoses, with studies showing that clinicians may hold low expectations for recovery (Angermeyer et al., 2011; Hinshaw & Stier, 2008; Knaak et al., 2017).

Psychological approaches within the psychosis pathway

Over the last twenty years, considerable attention has been given to the development of adjunctive psychological interventions seeking to support the social and psychological needs of people accessing ‘psychosis’ services (Lincoln & Pederson, 2019). The profile of evidence-based psychological therapies has been enhanced with the publication of clinical guidance from the National Institute for Health and Care Excellence (NICE, 2002, 2009, 2014). The opportunity for family interventions (FI) and cognitive-behavioural therapy for ‘psychosis’ (CBTp) is recommended for all service users across the ‘psychosis’ care pathway (NICE, 2002, 2009, 2014). Not without challenge (see Mollon, 2009; Coghill, 2015), NICE guidelines have sought to standardise provision and improve care across services (Ince et al., 2015).

In practice, access to psychological approaches remain variable. The 2012 'National Audit of Schizophrenia' (NAS), for example, reported that just 39% of people accessing services had, on average, been offered a psychological intervention (Royal College of Psychiatrists, 2012). A later analysis of NAS data from 2011 and 2013 further indicated ethnic minority disparities in those offered CBT relative to white service users (Das-Munshi et al., 2018). More recently, national audit data for Early Intervention (EI) services (Royal College of Psychiatrists, 2020) demonstrated that 76% of those under EI had been offered CBTp, with 63% offered FI. While uptake for CBTp is around 49% and for FI, 21% (Royal College of Psychiatrists, 2020), the increase in offering psychological interventions within EI services is likely a response to recent targets requiring access to NICE-approved care within two weeks of referral (NHS England, 2019). The rapid progress in implementation within the context of sustained attention, resourcing, and accountability highlights the role of the organisational context in supporting implementation. This energy is not necessarily mirrored within other services on the 'psychosis' pathway.

Barriers to the implementation of psychological approaches have been located at organisational, team, and service user levels (Berry & Haddock, 2008; Prytys et al., 2011). In a systematic review of this literature, Ince et al. (2015) identified organisational factors such as workload pressures, lack of protected time, and the prioritisation of crisis management as barriers to resourcing therapy (Williams, 2008; Kuipers, 2011; The Schizophrenia Commission, 2012). At a team level, staff alignment with a biomedical model of 'psychosis', and a lack of value placed on psychological approaches, were associated with the psychological needs of service users not being identified or prioritised (Braehler & Harper, 2008; Lewis et al., 2012; Williams, 2008). Lastly, at a service user level, difficulties in engagement, over-medication, and being ‘too symptomatic’ were cited as barriers to therapy (Bailey et al., 2003; Onwumere et al., 2014; Williams, 2008). Initiating and sustaining change in complex and dynamic systems, such as healthcare is challenging. Indeed, Braithwaite (2018) has argued that it is the interactions, relationships, and learning within local organisational cultures that govern the delivery of care far more than top-down directives.

Complex organisations

In recognition of the ‘hyper-complexity’ of health care systems (Klein, 2015), some researchers have argued that in emphasising control and structure, dominant research methodologies that guide implementation (e.g., randomised controlled trials) fail to account for the needs of complex systems (Kernick, 2006). The implementation literature has increasingly embraced complexity theory as a lens to conceptualise mental health systems (Ellis et al., 2017), with specific attention paid to changes in processes (Grol et al., 2013) and clinical leadership (Minas, 2005). This turn towards complexity has, however, been criticised. According to Brainard and Hunter (2016), the added value of a complexity lens remains inconclusive, with limited attention to cause and effect. Moreover, Long et al (2018) have argued that the literature is further complicated by an emerging demarcation between social complexity theory (as applied to humans) and the positivist aligned classical complexity theory (applied to everything else). In recognition of the limited applications of the descriptive epistemological positions held by some social complexity theorists (e.g., Goldstein, 1991), Pawson et al., (2005) have proposed a critical realist approach to evaluating complexity, while others, such as Long et al., (2018), have argued for an approach grounded in pragmatism, positions which offer directions for application.

When viewing service contexts as ‘complex adaptive systems’ (Plsek & Greenhalgh, 2001), the focus is placed on the relationships between interacting agents distributed across multiple levels of the system (individual, team, and organisational). Here, agents are interconnected ‘such that one agent’s actions change the context for another’ (Kernick, 2002 p. 122). It is acknowledged that agents self-organise, acting according to their own cognitive models (e.g., the result of professional training and experience) and internalised principles (e.g., values and beliefs), rather than adhering to imposed policy changes (Ellis et al., 2017). Guided by a shared vision (i.e., the ‘attractor’), agents can share and alter these internal models through localised interactions, with resultant patterns of behaviours considered emergent (Thompson et al., 2016) and not entirely predictable or controllable. These observable patterns are recognised as ‘organisational culture’ in other areas of the literature (Shein, 1996). When seen through the lens of complexity, implementation of new practice is considered an emergent and dynamic process (Braithwaite et al., 2018) embedded in systems with their own history and culture (Kernick, 2002).

Project aims

Through developing a grounded theory, the aim was to contribute to the literature by exploring how psychologists understand and negotiate the impact of the organisational context on the facilitation of meaningful individual therapy (as they perceive it) with people with psychosis-related diagnoses. Given that recent research has suggested a greater role for developmental trauma in the aetiology of ‘psychosis’ than previously highlighted, understanding experiences of furthering a psychologically informed understanding of ‘psychosis’ across the service pathway supports calls for greater attention to trauma-informed care (see Bloomfield et al., 2020).

This project was guided by the following research questions:

a. How do participants understand the organisational context in which they work?
b. What do participants feel it is about the team dynamics within the organisational context that enables them to work with people who have diagnoses of ‘psychosis’ and what makes it difficult?
c. In terms of the ways that psychologists feel able to support service-users towards therapeutic goals, what role do they see for the service context?

Method

Design

Grounded theory is a systematic qualitative research design, enabling the researcher to construct an explanation of a social process or action ‘grounded’ in participant data (Creswell et al., 2007). In using this methodology, the researcher “enters the phenomenon, gains multiple views on it and locates it in a web of connections and constraints” (Charmaz, 2006, p. 187). As this study is seeking to understand the experiences of psychologists embedded within different contexts and relationships, grounded theory offers an appropriate method of inquiry.

This project is guided by constructivist grounded theory (CGT) differentiated by Charmaz (2006). The constructivist ontological position recognises that knowledge is constructed in the interaction between humans, in relation to their environments (Crotty, 1998). In aligning with this position, I acknowledge that both my data and analyses have been created in relationship with the participants in this study (Charmaz, 2006, p.130). Due to unavoidable challenges with recruitment and the time-limited nature of this project, I adopted an abbreviated version of CGT (Willig, 2008). Interview transcripts were analysed following CGT guidelines, however, theoretical sampling in its fullest conception was not employed. Implications of this will be considered throughout.

Ethical considerations

Ethical approval was obtained from the Salomons Institute for Applied Psychology Ethics Panel (appendix E). All participants were provided information sheets (appendix F). This information was additionally located on the research website: (https://workingwithpsychosisstudy.wordpress.com). Willing participants were provided informed consent forms (appendix G), which were signed and returned prior to interview. The limits of confidentiality were stated within the participation information sheet and reiterated prior to interview. As part of the interview schedule, participants were asked to discuss their understanding of their work with two clients. In order to maintain anonymity of clients under discussion, participants were asked to provide pseudonyms. On transcription, care was taken to remove all information that could potentially identify participants and clients. The lead researcher had sole access to the audio data, which was deleted following transcription. All research data were securely stored according to General Data Protection Regulation (GDPR) requirements.

Participant recruitment

Counselling or clinical psychologists with a minimum of one-year post-qualification experience working with people with psychosis-related diagnoses, were considered eligible for this study. To enable visibility of this project, the study was advertised across a number of locations (see Table 1).

Table 1

Recruitment locations

Recruitment location	**Marketing medium**
British Psychological Society (BPS), Division of Clinical Psychology (DCP) Faculty of Psychosis and Complex Mental Health distribution list	Poster (see appendix H); Website-sent via email
International Organisation Promoting Psychological and Social treatments for Persons with Psychosis (ISPS) distribution list	Poster and Website sent via email
Clinical Psychologists UK Facebook page	Poster and Website
Salomon's Institute for Applied Psychology faculty member's distribution list	Poster
Twitter, with distribution enabled by key researchers within psychosis-related research	Website

Convenience sampling was initially employed, approaching personal contacts via email. This was followed by both snowball and further convenience sampling. To support the inclusion of a range of experiences, contexts and perspectives, participants were asked to complete an initial screening questionnaire (appendix I) hosted by Qualtrics. Through this questionnaire, participants provided their contact information, enabling first contact. Participants were asked to provide information about their service context, geographical location, therapeutic orientation, and training backgrounds. This information enabled a level of theoretical interview development in the absence of true theoretical sampling.

Participants

Of the 21 psychologists who completed the screening questionnaire, 14 consented to be interviewed. Table 2 provides demographic and contextual detail of the final sample. Service contexts from across the ‘psychosis’ pathway were included in this study.

Table 2

Participant demographic and contextual information

Participant	**Age**	**Gender**	**Ethnicity**	**Year qualified**	**Service context**	**Length in post**	**Geographical location**	**Time working with client group**
1	35-40	Female	White	2011	Early Intervention Service (EIS)	3 years	South East England	8 years
2	35-40	Male	White British	2010	Inpatient and Community Rehabilitation service	6 years	South East England	10 years
3	30-35	Male	White British	2018	Early Intervention Service (EIS)	1.5 years	South East England	6 years
4	40-45	Male	White British	2007	Inpatient Acute Service	4	London	13 years
5	40-45	Female	White British	2010	Community Psychosis Service	6 years	London	20 years
6	35-40	Female	British Indian	2014	Inpatient Rehabilitation Service	3.5 years	West Midlands	6 years
7	30-35	Female	White	2015	Community Rehabilitation Service	1 month	London	4.5 years
8	30-35	Male	White British	2014	Youth Secondary Care service	5 years	East Anglia	5 years
9	50-55	Female	White British	2002	Community Adult Mental Health Services (CMHT)	6 years	South East England	15 years
10	30-35	Male	White British	2017	Forensic Inpatient Service	4 months	South East England	8 years
11	55-60	Male	White British	1992	Assertive Outreach and Inpatient Rehabilitation Services	9 years	South Wales	23 years

12	45-50	Female	White British	2006	Early Intervention Service (EIS)	1 year	South East England	3 years
13	45-50	Female	White British	2005	Promoting Recovery Service	3.5 years	London	13 years
14	35-40	Female	White British	2017	Recovery Service	2.5 years	London	2.5 years

Note: South East (refers to contexts outside London)

Data Generation

Semi-structured interviews were conducted using secure video conferencing platforms (Skype and Zoom). Interviews lasted between 38 and 80 minutes, with an average of 60 minutes. Interviews were conducted according to the 'intensive interview' guidelines outlined by Charmaz (2006). This strategy elicited detailed idiosyncratic responses to questions regarding participants' experiences of the service context and how they understood their role within them. Consultation with a service-user involvement group helped to refine areas of interest (e.g., how do participant's define service user 'benefit'). The resultant interview schedule (see appendix J) was created in consultation with an experienced GT researcher and guided by the constructivist frame (e.g., clarifying participant understanding, asking about specific events). As interviews were completed prior to data analysis, my reflective journal, memos, and conversations with the lead supervisor guided interview refinement. My aim was to achieve the 'theoretical sufficiency' described by Dey (1999).

Data management and analysis

Following transcription, the complete data set amounted to 132,080 words of text. Landscape tabling within Microsoft Word was selected as a means of organising initial data, allowing constant contact with participants' words. The comment function in word enabled memoing throughout. Later stages of the coding process were completing using Microsoft Excel to enable ease in constant comparison. Based on guidance by Charmaz (2006), Table 3 describes the processes of analysis. In practice, this was iterative, moving back and forth between each stage using 'inductive-abductive' reasoning (Charmaz, 2009).

Table 3.

Process of data analysis

Stage	**Description**
Initial (open) coding	The first ten transcripts were coded line-by-line using gerunds. This helped retain connection to the participant and their action. Use of 'in vivo' codes (participant's own words) further helped "to keep that life in the foreground" (Charmaz, 2000, p.526). The remaining four interviews were coded using focused coding.
Focused coding	Salient and frequent initial codes were identified and elaborated to form focused codes. These were then used to guide further analysis (Thornberg & Charmaz, 2014)
Theoretical coding	Processes of diagramming and theoretical memoing facilitated exploration of the properties of codes and the possible relationships between them. Appendix L demonstrates the model's evolution over time.

Memo-writing was completed throughout, providing a means of conversing with myself (Charmaz, 2006, p.72) and enabling a record of connections, decisions, and questions arising from interaction with the data.

Quality assurance strategies

Implicit within CGT is the assumption that 'data and analyses are social constructions' (Charmaz, 2006, p. 131). Both my role as a trainee clinical psychologist, and my own experiences working in services undoubtably shaped every stage of the grounded theory. A number of strategies were useful in bringing "such knowledge into the open, to discuss how it affected theory development" (Cutcliffe, 2000). Advocated by Simon (2011), a bracketing mind map (appendix K) and interview provided a way of developing 'methodological self-consciousness' (Charmaz, 2017). These were used to develop a positioning statement (appendix M) and an abridged version is provided below. A reflective diary (appendix N) was also kept throughout, tracking my own interaction with the research process. In adherence to guidelines concerning transparency (Charmaz & Thornberg, 2020), thought processes were explicated throughout in memos and diagrams (appendices O-Q), as well as in discussion with my research supervisor.

Positioning statement

I am a white British female in my early 30s, located in South East England. This research forms a part of a Doctorate in clinical psychology. Since graduating, I have worked in various services across the 'psychosis' pathway, observing differences in the ways the organisation has impacted on professional helping relationships. Given the differences in the ways in which contexts enable attitudes of hope and possibility, it is my belief that there is a need for change. Through this research I hoped to gain an understanding of how organisational contexts and cultures interact to shape what is therapeutically possible, thereby demonstrating where there is scope for change.

Results

Overview of the model

This grounded theory seeks to illustrate the processes that psychologists working in services across the 'psychosis' pathway use to negotiate the organisational context when working with people with psychosis-related diagnoses. The research questions were used to help focus the interviews and as such will not be specifically addressed. Theory-building was instead guided by participant data. Findings were constructed into three domains: 'Navigating a complex system', ‘Stepping into authority’ and ‘Influencing change’. Together, these domains comprise eight constructed categories.

The grounded theory will be presented in the following format:

- Table 4 outlining the main social processes constructed from the data will be presented.
- A narrative description of the developed theory with organisational factors that participants saw as supporting and impacting on these processes. Each category will be presented in turn alongside illustrative quotes.
- Figure 1, a theoretical diagram, entitled ‘A complex system to navigate’, provides a visual representation of the categories and the relationships between them.

Table 4.

Grounded theory: Main social processes

Domain	Category	Category description	Sub-category
Navigating a complex system	1. Determining a service user's ‘willingness to rock the boat’	Participants stressed the relationship between trauma and psychosis, recognising different ways people have found to cope. Reflecting on someone’s readiness to try psychology, participants identified the interplay between a person’s history in services, openness to alternative ways of thinking, and expectations of psychology. Psychologists recognised that people often indicated difficulties in timing or connection by choosing not to attend. .	1.1. Place on the pathway 1.2. Service user's receptivity 1.3. Service user's expectations 1.4. Voting with their feet
	2. Negotiating team dynamics	Team dynamics are the interrelated psychological forces that shape team functioning. Reflecting on how the team may shape psychological work with people, participants spoke about the role of team culture and leadership. Participants perceived these to mediate individual team members openness to alternative ways of thinking and expectations of psychology.	2.1. Team culture and leadership 2.2. Team expectations 2.3. Team receptivity

	3. Adapting to organisational change	Participants described how their experience in services was constantly set against a backdrop of change. Participants reflected on challenges and opportunities of organisational change and shifts in ideas. For many these changes highlighted the fragility of the 'psychosis' specialist role and the need to find ways to hold on to this specialist knowledge.	3.1. Constant reconfiguration 3.2. Shifts in ideas
Stepping into Authority	4. Defining the Psychologist's role	How participants understood their role was influenced by a number of factors. Participants described their role as 'multifactorial', providing a psychological lens at different levels to support understanding of 'psychosis' complexity. Ability to shape and define their role was connected to the vision they had for the service. Ability to shape that vision appeared mediated by their history in services. The self of the psychologist was connected to reasons for choosing this work.	4.1. Psychologists' identity and Vision. 4.2. History in services 4.3. Understanding the self
Influencing change	5. Using the relationship	Participants reflected on the centrality of relationships in their work, both with clients and with the team. Participants reflected on the importance of spending time to develop trust, which enabled the next stage, 'making sense together'.	5.1. With Service user 5.2. With team
	6. Making space	Making space' captures a key mechanism for shaping a psychological approach with the team. Participants perceived authority within their role impacted their ability to make space and was mediated by their relationships with the team.	6.1. With team
	7. Making sense together	At the heart of the model is 'making sense together'. This refers to the building of a shared and integrated narrative to support cohesion and a consistent approach. Participants felt that meaningful therapeutic success was a result of being alongside and helping to make sense of their client's experiences. This process was equally important with the staff team.	7.1. With team 7.2. With service-user
	8. Service user taking ownership of the work	As a result of making sense together, participants described how beneficial work involved a process of the service user then taking ownership, regaining a sense of control and agency.	8.1. Service user taking ownership

Domain 1. Navigating a complex system

This domain relates to the processes used by psychologists when navigating multiple layers of context. Psychologists' work with individuals with psychosis-related diagnoses occurs within the context of teams, themselves existing within wider organisational and societal contexts. As such, the model (see figure 1) attempts to capture the embedded nature of these relationships through nested and overlapping circles. The following categories were constructed within this domain: 'Determining a service-user's willingness to rock the boat', 'Negotiating team dynamics', and 'Adapting to organisational change'.

1. Determining a service-user's willingness to rock the boat

Participants described the significant role that trauma has played in the lives of the people they are working with. Many described the *"huge links between trauma and psychosis" (P1),* while others viewed "*psychosis as trauma" (P5 & P13*). Participants recognised that some people have developed their own ways of coping with their experiences (e.g., through "*avoidance" (P5), "isolation" (P3)* or using "*cannabis" (P1)*)*,* which can become obstacles to engaging with psychology. The four sub-themes below represent interconnecting factors that impact on a service-user's readiness to try psychology.

1.1. Place on the 'psychosis' pathway. Willingness to try a psychological approach was often felt to be related to someone's prior experiences within services. Participants discussed how people accessing services at the later stages of the 'psychosis' pathway often had more complex personal stories, with negative experiences impacting on establishing a therapeutic relationship.

> *"… I think her experiences at that other team, which were controlling, disempowering, blaming, kind of started us off on the wrong foot" (P1).*

Often reflecting the length of time living with a psychosis-related diagnosis, location on the 'psychosis' pathway interacted with someone's willingness to consider alternative ways of approaching their experiences and expectations for what psychology can achieve.

1.2. Service-user's receptivity. Participants described needing to navigate the client's own interpretations and ways of managing their experiences. Participants explained that people could be reluctant to reconnect with their experiences of *"chaos" (P4), "distress" (P3)* and "*trauma" (P2),* concerned that this may take them back to a frightening place:

> *"…he's really in a place where he's like 'I'm all right at the moment- so, why would I want to talk about anything? Because I feel alright. I don't want to rock the boat'" (P6).*

Timing of interventions was important, with transitions or crisis seen as opportunities to try something different:

> *"...relapse is a time of time of crisis- they're like they're prepared to rock the boat cos the boat's already been rocked kind of thing" (P5).*

Willingness to consider a psychological approach influences and is influenced by the expectations that people have of psychology.

1.3. Service-user's expectations. Participants reflected on the expectations that service-users can hold regarding psychology, influenced by previous interactions with the mental health system. Some people have been told *"you are going to be ill forever" (P9)*, therefore expectations for change may be seen as not possible, or even "*quite threatening" (P14).* Participants explained that being given a medical understanding of their experiences by the team can impact people's expectations.

> "*…they want you to be able to instantly take away or they want you to go to get rid of experiences, because that's what they've been told could happen with a pill" (P9).*

Expectations set up by a medical narrative can lead to a search for "*practical tips"* rather than "*understanding distress" (P3),* which may not feel as useful. Participants recognised that unmet expectations may lead people to disengage.

1.4. Voting with their feet. One way people communicated difficulties with therapy is by *"voting with their feet" (P3).* Aside from expectations described above, participants further identified people not being *"quite ready" (P13),* or that *"the approach that was being offered wasn't meeting their needs" (P3).* At an organisational level, participants described how service models offering a minimum three-year service enables people to return when they are ready and therefore "*more on their terms"* (P6). At a service level, having a team who are accepting of when people disengage but "*willing to re-refer later on" (P1)* was identified as important.

2. Negotiating team dynamics

Participants viewed the interactions and functioning of their teams as guided by underlying psychological processes. These include the attitudes, beliefs, and accepted practices dynamically developed over time. Participants reflected on the difficulties that come with *"trying to fit into a culture where there is an expectation that we treat distress rather than understand" (P3).* As team culture and leadership are inextricably bound, participants reflected on the importance of individual leaders in mediating their experience of the team.

2.1. Team culture and leadership. The recognition that practice is more *"personnel driven than it's, kind of, organizational principles" (P4)* was shared by participants, with experiences in the team often dependent *"on the nature of your psychiatrist that you work with" (P6).* Participants reflected on the importance of having psychiatrists invested in sustaining the team ethos (e.g., around positive risk).

> *"…they've been replaced by locums, and locums I know, aren't thinking necessarily about long-term stuff a lot of the time…" (P11).*

When thinking about the conditions necessary for thinking together as a team, the psychiatrist's ability to *"enable others to contribute" (P14)* was an important factor in creating psychological safety.

> *"…she [the psychiatrist] was very, very hierarchical…and it led to quite an unsafe feeling in the team. That to express how you felt, I think, or to express any anxiety, was to express some kind of weakness that she may capitalize on later" (P7).*

Team culture and leadership both mediated the expectations that the team had of psychology and their receptivity to considering an alternative perspective.

2.2. Team receptivity. Within these medically oriented teams, participants felt receptivity was often dependent on the extent to which team members "*value psychology" (P9)* and influenced by the different frameworks that people have for understanding distress.

> *"…you say some psychological ideas to non-psychologists, it can sound a bit strange… because other trainings don't think about a person's context, let alone a person's history" (P6).*

While it could feel challenging working in a team where colleagues do not consider context *"relevant or important" (P6),* participants also described examples where team members were "*enthusiastic" (P11)* and *"eager to listen and take on board" (P5)* psychological or trauma-informed approaches to working with 'psychosis'. The ability for the psychologist to offer a psychological lens at multiple levels of the system often interacted with the expectations that teams had for psychology.

2.3. Team expectations. Participants described a range of expectations they felt were held by the team. Some felt their team could hold unrealistic expectations of psychology, for instance, that *"I'm going to have some magic wand" (P13)*, or there were expectations to produce grand results: *"We've done the medication bit. What are you going to do to sort out the rest?" (P10).* Participants perceived these expectations to be the product of a medically-dominated culture, where therapy *"gets described as an intervention and… as a therapist I might then offer some sort of solution" (*P3).

Access to resources (e.g., funding, psychology positions) played a role in team expectations for psychology. One participant described how increased resources meant that *"everybody becomes somebody who's good for psychology" (P7)* regardless of service-user interest or clinical judgement. This situation was, however, unusual, with most participants operating in psychologically under-resourced contexts, limiting what is possible. Participants reflected on how clinical training has changed over time to think more systemically but that team expectations can be based on "*more traditional individualistic models where the psychologist kind of comes in and does individual sessions of therapy" (P14).* Participants recognised the importance of *"helping people to understand what the role of psychology might be" (P6)* in realigning expectations and managing clinical resources effectively.

3. Adapting to organisational change

Participants reflected on how their experience within services is set against a constant backdrop of change. Organisational and service-level changes have brought challenges and opportunities for ensuring meaningful work with people with psychosis-related diagnoses.

3.1. Constant reconfiguration. Participants had all experienced organisational change, either directly or due to cuts to services around them. Changes were described as "*challenging"* and *"always quite disruptive" (P11).* Two participants, located in specialist 'psychosis' services, were undergoing a transformation back to 'generic' CMHTs. While this move brought some opportunities (e.g., reducing the need for diagnostic certainty), participants expressed disappointment and frustration that *"sometimes decisions are based on money rather than clients' needs" (P13).* With the loss of specialist 'psychosis' services, participants recognised the loss of collective knowledge, *"all that expertise, I think, is gone" (P5).* One participant in a 'generic' service described the danger with not having dedicated provision: "*if I was ever to get sick or leave, then all my expertise goes with me and it becomes a single point of failure for the kind of psychosis provision of psychology" (P8)*, returning 'psychosis' to the "*remit of the medics" (P8).*

3.2. Shifts in ideas. Changes in evidence and clinical guidance has led to the implementation of new ways of working. In moving from an 'assertive outreach' to a 'community rehabilitation' model, one participant explained how these shifts in philosophies has impacted upon the team *"the assertive bit and the engagement bit has maybe gone a little bit now" (P2),* with the loss of defining values *"quite an adjustment to get used to" (P2).* Participants recognised how trauma-informed care is becoming *"increasing important throughout the whole of the NHS" (P5).* Trusts are "*listening to the evidence-base*" *(P4)* and funding training in trauma-specific therapies, which they felt was positive. Some participants discussed how services were moving more towards being accountable and evidence-based, "*making sure we meet NICE guidelines erm for for all of our people rather than just hoping that we do" (P1).* With accountability, however, there has also been an inadvertent shift towards diagnostic certainty, impacting on "*who is accepted and who isn't" (P12).*

Domain 2. Stepping into authority

This main process in this domain is 'defining the psychologist role'. Embedded within more medically oriented teams, participants recognised that part of their role was to "*challenge" (P1)* and hold a "*counter position" (P3).* Given the fragility of specialist provision, participants spoke about using their *"power and position as a psychologist to try and spread that stuff outwards and protect that more strongly" (P8).* To some extent, these leadership tasks were formally embedded, but there was variability in the opportunity to step into this authority, influenced by participants freedom to define their role.

4. Defining the psychologist's role

Participants felt the autonomy and flexibility afforded to them by the service supported effective working. Service arrangements, however, influenced the extent to which participants were able to define their role. Some participants recognised the benefits of "*not being a psychology department and there not being rules about who we see and what we do" (P1).* For others, the flexibility required *"can also affect my role and boundary issues sometimes er can make therapy tricky" (P2).* The sub-categories relate to the different experiences and influences that have shaped the psychologist. Together, these different factors potentially mediate the psychologist's ability to define their role and enact their vision.

4.1. Psychologists' identity and vision. Participants' clinical experiences and additional training shaped how they saw their role, with many considering themselves "*a specialist in psychosis" (P13).* At an individual level, participants wanted to provide people with psychosis the *"opportunity to have a psychological approach to their experiences" (P9).* One participant explained, *"our job as psychosis psychologists is to make sense of the symbolism and make sense of what's going on for that person" (P5).* Other participants highlighted the importance of "*helping the system to think and to consider the people they work with in more psychologically informed ways" (P10).* Participant 11 noted that just being present in the team can help change the discourse:

> *"…they're quite likely to kind of lapse into this, you know, 'they're paranoid'… 'this is just a delusion' kind of thing. So, they are quite likely to lapse into that when I'm not around" (P11).*

Participants viewed their role as helping people *"think in a more complex way about psychosis" (P1).* This was particularly important given the move towards services embracing trauma-informed care. Participant 1 considered it their role to help the team feel more comfortable assessing and working with people with complex trauma *"making sure they also get a service rather than saying 'no its just all its just all interpersonal stuff and we don't deal with that" (P1).*

4.2. History in services. Participant's length of experience within services varied, impacting on how they perceived their role. Participant 14 reflected on how being newly qualified initially made them more "*accepting of the way that things are"*, while participant 3 described how their view of core tasks moved from predominantly individual work towards "*more working with the team'.* There was also recognition that "*organisational influence" (P4)* was related to banding. Explaining the additional responsibilities that come with seniority, one participant stated, *"…we are trying to set the agenda…. shaping the team, shaping the service, fighting with management about what we need" (P5).*

One participant reflected on how other people are more receptive to her ideas as a result of her experience in services*: "there's a certain, there's a certain confidence that you have, isn't it? People feel held by, by that" (P12).* Other participants reflected on prior experiences *"working* *with a medic who doesn't place any value in the work you're doing" (P8)* or in services where "*the team don't don't necessarily feel like psychology works or helps" (P2).* The legacy of these experiences may have shaped participants confidence in actively shaping the service direction.

4.3. Understanding the self. The integration of professional knowledge and experience (what one knows) with one's personal values, beliefs and traits (who one is) was felt to be important by participants. Where teams were able to embody a trauma-informed approach, participants reported feeling "*more comfortable to work in that team and being a person in that team that have my thoughts and views" (P5).* Reflecting on the difficulties of being embedded in a service in which core values or beliefs were misaligned, participant 6 articulates the value of supervision in being able to sustain their work.

> *"There have been moments when I am like what am I doing? Why am I here? … Why am I the only person that thinks this person's trauma history is relevant to the fact that they're having psychotic experiences now? Erm but I suppose over time, you know, I have a lot of supervision I suppose- erm I pay for extra so to help me think about these things" (P6).*

Domain 3. Influencing change

This last domain relates to the processes used by psychologists to influence change. In recognition that these processes occur across multiple layers of context, this domain occupies the central portion of the model. The following categories were constructed within this domain: 'Using the relationship', 'Making space', 'Making sense together', and 'Service-user taking ownership of the work'.

5. Using the relationship

Operating at the intersections between psychologists, service-users and teams, the process of 'Using the relationship' enables psychologists to achieve the central process, 'Making sense together'. As demonstrated in Figure 1, relationships are considered essential to psychologists' negotiation of multiple contexts, enabling them to meet their goals.

5.1. Using the relationship with clients. In order to 'influence change', participants recognised that the therapeutic relationship formed the foundation for therapeutic work:

> *"[the relationship] enabled her to, I think, be able to talk about her psychotic experiences… there was a strong enough attachment in the relationship that we could talk about stuff and it would be okay and start to make sense of it all" (P4).*

Participants felt the flexibility afforded by services was an enabling factor in developing relationships. Participants were not confined to clinic rooms, feeling that engagement was enabled by going out to *"meet them [service users] where they are" (P13).* Service level obstacles to developing relationships were also identified, with more restrictive environments posing difficulties. Developing a trusting relationship is difficult when seen as part of a system that has "*power-over" (P10),* "*makes people worse, or traumatizes them" (P9)*. A further organisational and systemic difficulty that comes with a limited psychological provision is lack of choice:

> *"… maybe that people could connect better with like either a man or erm a person of colour or ….class base, I guess…. If we can't make a connection, then you have no choice" (P1).*

5.2. Using the relationship with teams. Participants discussed the importance of working together with the team, recognising that "*people's needs are so complex and so beyond* *psychology, that psychology has to work within the wider context" (P7).* Participants spoke about the value of providing 'informal' or 'indirect' work with the staff team, seeing their role as "*supporting staff in their well-being so that they're able to support service-users" (P6).* Where relationships had been established, participants felt they would *"be more likely to be having a bit more of an influence on what other people are doing" (P11).*

Many participants described their role as helping support the relationship between the team and service-users. This was done through mechanisms such as modelling and building in spaces for the team to think together:

> *"...really understanding what we do as working with traumatized people, and that therefore that will influence the questions that we ask, what we pay attention to… how we talk about this client…how we tried to build a relationship with them" (P5).*

6. Making space

Reflecting on the significant pressures that teams were under, participants felt part of their role was "*to maintain space for thinking, to slow people down, to help people understand, understand and formulate difficulties more holistically" (P8).* Participants achieved this through a variety of means (e.g., offering team formulation sessions, reflective practice, consultation, regular training, quality circles, and clinical supervision). One participant felt that facilitating these spaces helped the team "*not only understand my role as being different to just an individual therapist, I hope it also does bring in a bit more psychological thinking" (P10).*

Participants' perceived ability to create space within the team was likely mediated by how much the team value psychology and the psychologist's ability to define their own role. In the context of a team in which leadership did not prioritise psychological safety, one participant explained that their team "*had no interest in any kind of reflective practice, they had no interest* *in really connecting as a team at all around feelings, apart from the feeling of anger" (P7).* In recognition of the need to create space to understand team dynamics, participant 1 described the importance of how they position themselves *"always having one foot in and one foot out of a team".*

Creating space to amplify service-user voices was also discussed, co-facilitating *"courses" (P9,) "forums" (P10),* "*peer support positions" (P9)* and "*training sessions" (P11).* One participant described these spaces as "*influential in terms of professionals having to take a bit of a step back and really considering the service- user perspective" (P10).* While pockets of good practice were acknowledged, participants felt that this would get lost at times of reorganisation, recognising that "*one of the things we have got to do is try to figure out some way of sort of hardwiring that stuff into the organisation" (P11).*

7. Making sense together

At the heart of the model is 'Making sense together'. This core process refers to the building of a shared and integrated narrative, which then supports a cohesive approach. This process occurs between participants and the team, between participants and service-users, and between the team and service-users. Success of this process is considered important to enabling beneficial outcomes with people with psychosis-related diagnoses.

7.1. Making sense with the team. One participant observed that within teams people used psychiatric shorthand "*where I don't think people know what they mean but use the language like it means something" (P11).* This lack of shared understanding extended to service philosophies such as the 'recovery' model. One participant observed that 'recovery' is *"quite a nebulous term and I think you see different ideas about what that actually means and that, I think, causes frictions and tensions" (P7).* Embedded in medically oriented teams, participants were at risk of contradicting other messages in the team, *"where I might be, again, just trying to make meaning with someone out of their distress… they [service users] might have subscribed to a medical explanation for their distress" (P3).*

Through the spaces described above the team can think together to develop an integrated understanding of a person's difficulties. One participant relayed how their team had found it helpful to locate their work within an overarching trauma model stating: *"…if you think about safety and stabilisation, all the work that the care coordinators do is to help someone feel safe and secure and stable" (P13).* One of the main barriers identified by participants, however, was that psychiatrists were often not present within the spaces created. Without investment from the psychiatrist, a coherent narrative remained hard to implement.

7.2. Making sense with service-users. Enabled by the relationship, participants felt that meaningful therapeutic work was a result of being alongside, helping people make sense of their experiences. Working in collaboration, participants described how they supported service-users to make connections between experiences *"like hearing a voice or feeling anxious, with like a trigger" (P2)* or "*linking past to present and kind of understanding where everything had come from" (P13).* In this way, participants were often *"sitting with the chaos and confusion and trying to make sense of it" (P4).*

Team support was recognised as important allowing participants to maintain therapeutic boundaries, the team would "*safety plan and risk assess and do things that erm meant that… I could sort of keep focus on sort of meaning making" (P3).* Regular team discussion also provided containment, which, for participant 1, enabled the formulation to guide decision-making "*I felt safe and held in my team… safe enough to do some really quite positive risk-taking stuff, I guess" (P1).*

8. Service-user taking ownership of the work

As a result of making sense together, participants described a process whereby the service-user starts to take ownership of the work. Through this process service-users were able to regain a sense of control and agency: *"...she is just taking it and she is running with it and she is doing an amazing job" (P1).* When reflecting on the service-level factors that support meaningful work, participants emphasised how *"the beginnings, the endings… has to be managed really well" (P13).* Despite the push to discharge, participants recognised that services could support the work by staggering discharge to allow "*a bit of time to kind of process everything and kind of things to settle*" (P13).

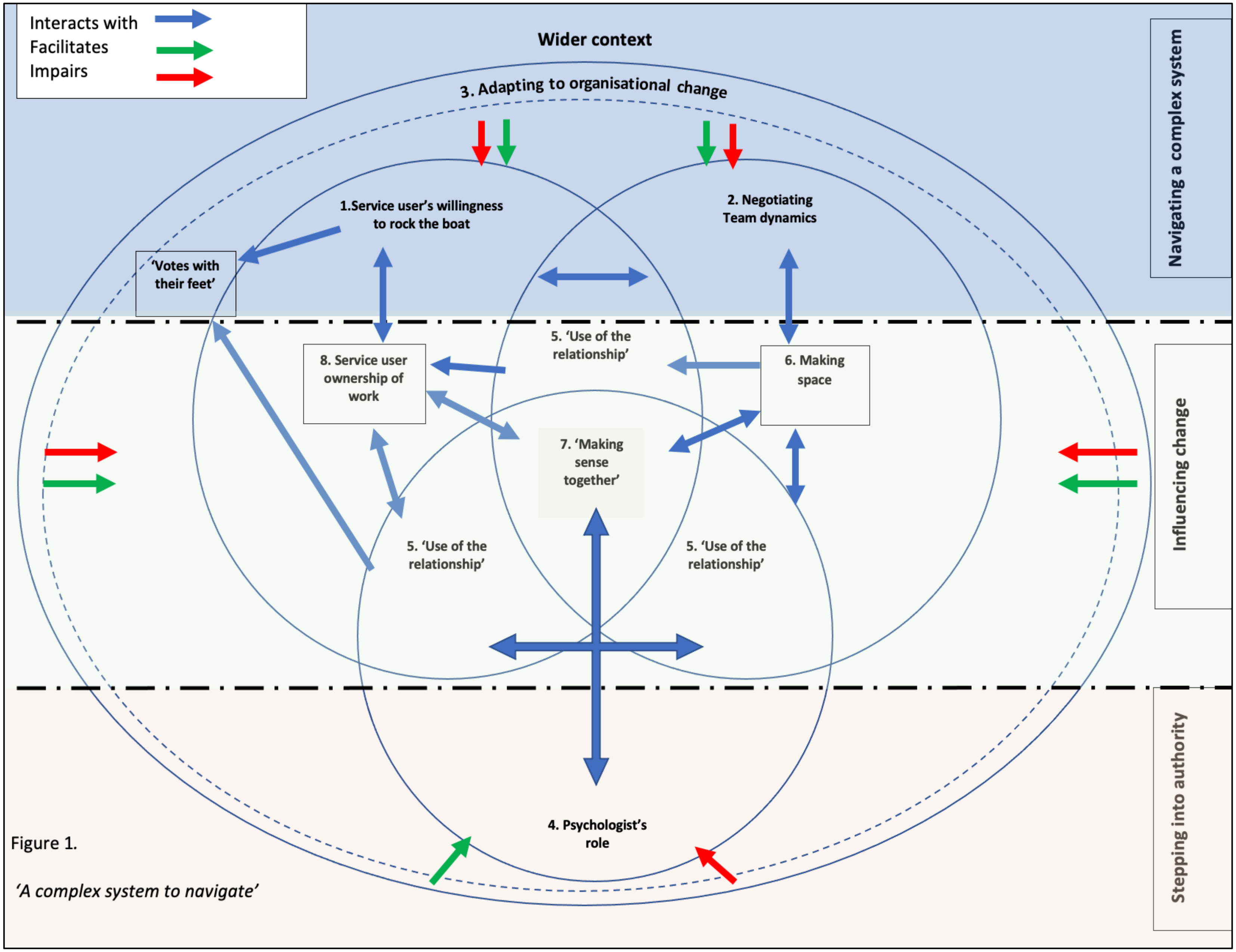

Figure 1.

'A complex system to navigate'

Summary

Pictorially represented in Figure 1, the emergent theory recognises that navigation of the organisational context is enabled through psychologists' holding an awareness of the multiple interacting forces that impact on their work at organisational, team, and individual levels. Psychologist's awareness of themselves in their role and the extent to which they hold a vision for change has implications for how they directed their influence. While constrained by organisational infrastructures, participants' perceived authority to create spaces within the service was further mediated by their relationship with the team. Within these spaces, participants could offer the team containment and supervision, as well as model compassion, thus reinvigorating team relationships with service users. These spaces further enabled the bringing together of multiple perspectives, co-creating a coherent understanding of service users' difficulties. At heart of the theory is 'Making sense together'. Creating opportunities for the team to make sense together better enables communication of a consistent message to service users. This then has potential positive implications for service users' expectations for, and receptivity to, psychological approaches to their difficulties. In their individual work with services users, participants emphasised that genuine attention to the relationship was foundational to therapeutic work. The trust developed within their relationships enabled the process of making sense together through dialogue. Through processes of containment and shared sense-making, service users were able to slowly take ownership of the work. Links to existing theories will now be explored.

Discussion

The research questions provided a useful guide in the creation of the model, illuminating dynamics of organisational change and inertia taking place at multiple levels of the system.

While not a study of implementation, participants, albeit to varying extents, located their role as agents of change, promoting a psychological understanding of ‘psychosis’ in a predominantly medical system. Indeed, by paying attention to the history of each system, the importance placed on relationships and in the creation of spaces for shared understanding, this grounded theory shares many similarities with implementation when considered through the lens of complexity (Grol et al., 2013).

Cultivating therapeutic relationships

Participants in this grounded theory considered the relationship foundational to therapeutic work, welcoming the flexibility afforded by the service to gently build relationships. The development of the therapeutic relationship has been identified within service user studies as key to perceived helpfulness (Sweeney, 2014; Wood et al., 2016), with a recent systematic review establishing alliance as crucial to therapeutic outcome (Shattock et al., 2018). The literature recognising the impact of trauma on the lives of people accessing ‘psychosis’ services is also well established (e.g., Bentall et al., 2014; Kessler et al., 2010; Varese et al., 2012; Read et al., 2014; Sweeney et al., 2016). While acknowledging heterogeneity in experience, awareness of the pervasive impact that trauma can have on shaping a person’s worldview and sense of interpersonal safety is therefore warranted (Isobel, 2016; Sweeney et al., 2016). Where services are trying to adopt trauma-informed approaches, there was acknowledgement that other parts of the ‘psychosis’ pathway could be disempowering and retraumatising, impacting on the development of the therapeutic relationship. Given that “traumatised human beings recover in the context of relationships” (Van der Kolk, 2014, p.210), it is important to draw attention to the way organisational structures may impact the therapeutic relationship (see Sweeney et al., 2018).

Within this grounded theory, developing relationships with the staff team was considered important for several reasons. Through the relationship, participants could support the psychological mindedness of the team, which has been shown to be positively associated with the capacity to form meaningful therapeutic alliances (Berry et al., 2008). Participants additionally discussed the importance of attending to staff wellbeing to support meaningful service-user care. As argued by Sweeney et al. (2018, p. 322), the vicarious trauma that can occur when working in strained, risk-focused, ‘trauma-uninformed’ environments can result in practitioners operating through the use of ‘power’ rather than relying on their ‘relational capacity’. Indeed, a recent evidence-based policy brief on NHS staff wellbeing has suggested that when staff members feel their wellbeing is valued by the organisation, they are better able to offer supportive care (Paparella, 2015). Participants’ attention to supporting the wellbeing of staff, informally, or through provision of supervision or reflective practice, thus provides a further example of how the actions of one agent can positively impact on another (Kernick, 2002).

Space for shared understanding

Within this grounded theory, ‘making space’ captured the ways participants sought to create opportunities for difference, interrupting established ways of thinking or acting.
While under-researched (Johnstone, 2014), team formulation is lauded as ‘a powerful way of shifting cultures towards more psychosocial perspectives’ (Onyett, 2007, p.23), with perceived enthusiasm reported by non-psychological staff (Hood et al., 2013). Participants recognised a team-level acceptance of formulation, however, many noted that the consultant psychiatrist was often absent from these spaces. Despite moves towards distributed leadership (Onyett, 2007, p.39), psychiatrists remain positioned as the dominant decision-makers in medically oriented

teams. It has been argued that for formulation to guide decision-making ‘it must be supported by influential members of the team’ (Lake, 2008, p.23). Trauma-informed, person-centred practice requires all members of the social context in which care occurs to engage with the shift in paradigm (Sweeney et al., 2018; Isobel et al., 2020).

The extent to which participants could formally or informally step into their authority was felt to be mediated by the organisational culture (e.g., team expectations regarding individualistic models of psychology) and the organisational climate (e.g., leadership negatively impacting on the psychological safety of the team). Where creation of formal spaces was limited by organisational factors, participants described the importance of holding a psychological lens at other opportunities (e.g., informal conversations, team meetings, ward rounds, training events, audit, and research). This is described elsewhere as sharing formulation-based thinking (Christofides et al. 2011; Johnstone, 2014). Further, the consistent presence of psychologists within the multi-disciplinary team (MDT) was potentially supportive of successful outcomes, for instance, through modelling hope for recovery (Berry & Greenwood, 2015), by supporting a change in language use (Onyett, 2007), or through influencing shared decision-making (Priebe et al., 2005).

Rather than attending to resistance, the literature on complex adaptive systems recognises that team operations are better influenced by attractors (Minas, 2005). Recent research identifying attractors within healthcare settings include establishing a shared vision for meaningful client care, strengthening interprofessional relationships, and improving personal and professional wellbeing (Pype et al., 2018). The results of this grounded theory are thus consistent with these findings.

Limitations

While theoretical sufficiency appeared to be met, the most critical limitation of this study was that theoretical sampling did not guide the evolution of the model. While knowledge (e.g., service context, experience, etc.) gained through the initial survey, reflective journaling, and supervision was helpful in guiding theoretical interviewing, it is possible that there may have been more to consider. The final sample was also small and lacking in ethnic diversity, which may have impacted the range of themes that emerged. Psychologists from a range of NHS contexts across the UK were, however, recruited. While it is possible that those who self-identified interest in the project may have espoused a more social model of mental health, there was, however, considerable heterogeneity in participants' experience, seniority, and service settings. Indeed, by focusing on common experiences, the study aimed to capture a broad model of how psychologists navigate the organisational context when working with people with psychosis-related diagnoses.

In constructing this research, my own preconceptions may have also influenced interpretation of the data as well as my interview style. The diary entry from 10.04.2020 (see appendix N), for example, notes *"I could see times where I may have 'known' too quickly",* thus recognising how my assumed knowledge may have impacted my curiosity at times when interviewing. Respondent validation received at the time of writing suggested that the model did seem to capture the challenges of being a psychologist in psychosis services.

Clinical implications

In attending to the relationship at all levels of the system, this study argues that psychologists offer a 'living leadership' (Binney, et al., 2005). Where service structures enable psychologists to create spaces to attend to staff wellbeing, formulation, and team dynamics, this can positively impact the relationships between the team and service users (Berry et al., 2008). While individual psychological work in these contexts remains important, attending to the staff team has positive implications for the experiences of service users as recognised in the leadership development framework (DCP, 2010). Taking time to establish coherent messages as a team may increase containment for service users and staff, potentially reducing the time needed at the early stages of engagement to address expectations and receptivity to psychology.

When seen through a complexity lens, even small actions can impact on the system. Indeed, it is through connection and interaction that diverse positions are shared enabling continuous learning and generating new behaviour (Anderson et al., 2014). Clinicians working in services resistant to psychological ideas should focus on understanding and building on localised ‘attractors’ for change (Plsek & Greenhalgh, 2001). Advocating for spaces which facilitate collaborative learning will be important in influencing team receptivity to psychological positions. The utility of these spaces will be enhanced when the full team are in attendance.

Conclusions and recommendations

This study explored processes used by psychologists to promote a psychological understanding of ‘psychosis’ within a predominantly medicalised system. In navigating the organisation, the participants involved in this study drew attention to the importance of therapeutic relationships, staff wellbeing, reflective practice, and creating a shared vision for meaningful care. While the findings presented are consistent with the growing literature on creating trauma-informed organisations (Bloom, 2006), this study has foregrounded the importance of what I have called ‘making sense together’, that is, the collaborative development of a coherent narrative to enable both organisational containment and person-centred care. It is in relation to this aspect of the study that several potential recommendations emerged.

Firstly, for care to be transparent and patient-centred, spaces where service users can support insight into the impact of care dynamics as well as help guide service development will need to be ‘hard-wired’ into the organisation. Secondly, to ensure the effective use of the psychological clinical resource, psychologists will need to work alongside staff teams in developing greater awareness of changes to the role of psychologists within the MDT. Thirdly, there is a need for medical and psychosocial practitioners to enter into a more explicit and sustained dialogue in order to enable coherent patient-centred care. Fourthly, it is important that mental health practitioners also reflect on the broader socio-economic context. As discussed, many of the obstacles faced by individuals and teams extend beyond the organisation. Sustained attention to societal causes of distress is thus needed in order to direct attention to the ‘communities where trauma occurs’ (Sweeney & Taggart, 2018, p.385). Finally, in viewing the above through the lens of complexity, this study hopes to offer a model with the potential to help clinical psychologists, particularly those newly qualified, in their thinking about the workplace context and where there may be opportunities for influence.

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Section C: Appendices of supporting materials

Appendix A: List of search terms for systematic review

Search	Search terms	ASSIA	Psych Info	Web of Science/ Medline	Psych Articles
1	("organi*ational culture" or "organi*ational climate" or "organi*ational context" or "organi*ational wellbeing" or "organi*ational values" or "organi*ational containment" or "organi*ational norms" or "organi*ation" or "organi*ational change*" or "healthy organi*ation" or "accepted practice" or "dominant practice" or "normative practice" or "dominant culture" or "prevailing culture" or "team culture" or "service culture" or "team working" or "team cohesion" or "organi*ational collaboration" or "team leadership" or "iatrogenic harm" or "institutional containment" or "reorgani*ation" or "target culture" or "medical model" or "psychosocial model" or "recovery model" or "biomedical" or "recovery orientation" or "blocked care" or "marginali*ation" or "distributive leadership" or "distributed leadership" or "traumati*ed system" or "trauma-informed" or "Just organi*ation" or "blame culture" or "just culture" or "organi*ational stability" or "organi*ational instability" or "staff wellbeing" or "mental health system" or "compassionate leadership" or "organi*ational impact*" or "organi*ational support*" or "psychosocially oriented" or "medicali*ed")	20,607	114,470	859,882	968
2	("professional experience" or "professional dilemma*" or "Professional conflict*" or "professional identit*" or "Professional challeng*" or "professional values" or "professional attitude*" or "professional autonomy" or "professional reflection*" or "professional philosoph*" or "role conflict" or "value* congruence" or "value* alignment" or "role ambiguity" or "personal philosoph*" or "personal value*" or "valued practice" or "moral dilemma*" or "ethical dilemma*" or "frustration*" or "professional perspective*" or "conflict*" or "value*" or "dilemma*" or "perspective*" or "attitude*" or "dissent*" or "professional understanding")	74,088	33,195	3,232,839	4,356
3	("mental health professional*" or "mental health practitioner*" or "mental health profession*" or "psychologist*" or "clinical psychologist*" or "psychological therapist*" or "therapist*" or "psychotherapist*" or "counselling psychologist*" or "psychosocially-oriented practitioner*")	44,995	44,292	45,124	1,448
4	("psychosis" or "psychot*" or "voice hearing*" or "meaningful recovery" or "schiz*" or "hearing voice*" or "positive risk" or "severe mental illness*" or "mental health problem*" or "mental health disorder*" or "acute" or "risk culture" or "diagnos*" or "disorder*" or "severe mental*")	205,163	311,077	4,570,076	4,256
	Search 1 AND Search 2 AND Search 3 AND Search 4	106	37	525	12

Appendix B: Inclusion criteria

Criteria	Justification
Conducted between 2011 to 2020	2011 marked the introduction of the recovery-orientated approach within government policy.
Examines mental health practitioner experiences	The term ‘mental health practitioner’ was used to capture the range of professional experience working with people with ‘psychosis-related’ diagnoses.
Mental health service context	Included studies are required to discuss the organisational context of a mental health service offering treatments to people with ‘psychosis-related’ diagnoses.
Original qualitative data	The review seeks to explore the experiences, attitudes or dilemmas of mental health practitioners, most appropriately obtained through qualitative research. Any study utilising survey data or statistical reporting of results will be excluded. Qualitative data from mixed methods studies will be included.
Published in the English language	Due to limited resources, the translation of studies published in languages other than English is not possible.

Appendix C: Modified CASP reviewers’ guidelines (Long et al., 2020)

Item	Guidelines
Q1: Clear statement of aims	***Yes***- Specifically states the research objective or why it was thought important ***Unsure***- Not clear ***No***- Research objective is not discussed
Q2: Appropriate qualitative methodology	Does the research seek to interpret or illuminate actions and/or subjective experiences of research participants? Exclude if inappropriate
Q3: Research design	***Yes***- specifically states research design with justification *(discussion of how they decided?)* ***Unsure***- outline of research design only ***No***- not discussed or inappropriate to research question
Q4: Are the study's theoretical underpinnings (e.g., ontological and epistemological assumptions: guiding theoretical framework) clear consistent and conceptually coherent?	• *To what extent is the paradigm that guides the research project congruent with the methods and methodology, and the way these have been described?* • *To what extent is there evidence of problematic assumptions about the chosen method of data analysis? e.g., assuming techniques or concepts from other method (e.g., use of data saturation, originating in grounded theory) apply to chosen method (e.g., Braun and Clarke’s reflexive thematic analysis) without discussion or justification.* • *To what extent is there evidence of conceptual clashes or confusion in the paper? e.g., claiming a constructionist approach but then treating participants’ accounts as a transparent reporting of their experience and behaviour)* ***Yes***- States theoretical underpinnings, consistent use of methods and coherent approach (see above) ***Unsure***- Does not make specific reference to theoretical underpinning, or evidence of problematic assumptions ***No***- Conceptual confusion evident
Q5: Recruitment strategy	***Yes***- Researcher explained how participants were selected and why they were appropriate for the research aims ***Unsure***- *Recruitment strategy unclear* ***No***- No explanation, or selected participants inappropriate
Q6: Data collection.	***Yes***- *addressed* 4 or more items of the following items: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g., focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g., tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data* ***Unsure***- addressed 2 to 3 items listed above ***No***- addressed less than two items

Q6: Relationship between researcher and participants	***Yes***- Researcher critically examined own role and potential bias throughout the research process (formulation of research question, data collection- including sample recruitment and choice of location?) ***Unsure***- limited discussion ***No***- Not discussed
Q7: Ethical considerations	***Yes***- Addressed 2 or more of the following: • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee ***Unsure***- Addressed one of the above ***No***- not discussed
Q8: Rigorous data analysis	***Yes***- in depth description of analysis process, sufficient data presented. Addressed 4 or more of the following items: • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during data analysis and selection of data for presentation ***Unsure***- Limited discussion of analysis process. Addressed 2 to 3 items listed above ***No***- Addressed less than two items
Q9: Clear statement of findings	***Yes***- Findings are explicit, credibility discussed *(e.g. triangulation, respondent validation, more than one analyst), are* findings discussed in relation to the original research question? ***Unsure***- Limited discussion of research findings ***No***- No, or inadequate, discussion of research findings
Q10: How valuable is the research?	***Yes***- Three of the below items discussed • the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used ***Unsure***- only two items discussed ***No***- Only one item discussed

Appendix D: Quality appraisal of identified studies using modified CASP checklist

First Author	Murphy et al. (2013)	Tickle et al. (2014)	Hanley et al. (2017)	Jones et al. (2018)	Cooke et al. (2019)	Crawford et al. (2013)	Stacey et al. (2016)	Sutton et al. (2016)	Brooks et al. (2017)	Ebrahim (2016)	Wood et al. (2019)
Clear statement of aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the research design appropriate to address the research aims?	Y	Y	Y	Y	Y	Y	Y	Y	U/S	U/S	Y
Are the study's theoretical underpinnings clear, consistent and conceptually coherent?	U/S	U/S	Y	U/S	Y	Y	Y	Y	U/S	N	Y
Was the recruitment strategy appropriate to the aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	U/S
Was the data collected in a way that addressed the research issue?	U/S	U/S	Y	Y	Y	Y	Y	Y	Y	Y	Y
Has the relationship between researcher and participants been adequately considered?	U/S	U/S	N	N	Y	N	Y	N	N	Y	Y
Have ethical issues been considered?	Y	Y	Y	U/S	U/S	U/S	Y	U/S	Y	U/S	U/S

Was the data analysis sufficiently rigorous?	Y	U/S	Y	U/S	Y	U/S	Y	U/S	Y	U/S	Y
Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	U/S	Y
How valuable is the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sampling strategy	N	N	U/S	N	Y	N	Y	N	Y	N	N
Reflexivity	SOME	SOME	N	N	Y	N	Y	N	N	Y	Y

Appendix E: Ethics Approval

This has been removed from the electronic copy

Appendix F: Participant Information Sheet
Version 2
05.03.2020

Information sheet for participants

Study Title: How do psychologists understand and negotiate the impact of the organisational context on their individual work with people with psychosis? A grounded theory.

Hello, my name is [redacted] [redacted] 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 which I am carrying out under the supervision of Dr Sue Holttum (AFBPsS, CPsychol). Before you make your decision, it is important that you understand why the research is being done and what the study involves.

Part 1 gives you information about the purpose of the study and what will happen to you if you decide to take part. Part 2 provides more detailed information about the conduct of the study

Part 1 of the Information sheet

What is the purpose of the study?
The purpose of the study is to explore how psychologists working across different organisational contexts within the NHS understand the work they do with people who have received a psychosis-related diagnosis (e.g. schizophrenia, schizo-affective disorder, 'psychotic illness'), and to consider the potential role of the organisational context on the work, from the psychologist's perspective. The aim is to then develop a model that captures this perspective.

Why have I been invited?
You have been invited to participate as you are a psychologist currently working with people who have received a psychosis related diagnosis. I hope to recruit between 10 and 15 participants to take part.

Do I have to take part?
It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. As this project will be using Grounded Theory methodology, I will be analysing each interview, and using the emerging concepts to guide subsequent interviews. This means that whilst you are free to withdraw without giving a reason, I ask that you would contact me within seven days after your interview if you wished to ensure that your data would not be used.

What will happen to me if I take part?
If you agree to be contacted regarding the study, I will contact you and discuss the study and answer any questions you might have. After this discussion if you agree to take part in the study, I will arrange an interview. The interviews can be done through video conferencing using 'Zoom' or Skype, or face-to-face if feasible. The interview is likely to last approximately one hour and will be audio-recorded. The purpose of the recording is to allow me to capture all the information discussed during the interview, which is important for me to analyse later. In the interview I will ask you questions about your experience of working with people with experience of psychosis, and about the organizational context in which you do this work. I will also ask for examples of when you have assessed a piece of work with a client as having a positive outcome as well as a time when you have considered a person to have had no appreciable benefit. I will ask what, if any, impact you feel the context might have had on the work with that client, and how you relate to the context.

You will also be offered the opportunity to respond to the emergent theory via email and to discuss how well you feel the results fit with your experiences, but this is optional. The results of this study will be written up as part of my doctoral project for my clinical psychology qualification and a paper will be submitted to a peer-reviewed journal.

Expenses and Payments
If you are required to travel, we will reimburse you up to £10 to cover any travel costs.

What are the possible disadvantages and risks of taking part?
Participants may find it difficult or distressing to discuss their experiences of working with people where there has been no appreciable benefit for a client or where the organisational context may have felt stressful, however I will take care to conduct the interviews sensitively and considerately. There will be an opportunity for a debrief following the interview.

What are the possible benefits of taking part?
Although there may not be any particular individual benefits to participating, it is hoped that this study will help to inform how to effectively work with people experiencing psychosis related conditions across different parts of their recovery journey, and especially to inform ways in which the organisational context might be made more conducive to the work, and to highlight some good organisational practices.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. I will disguise all identifiable information including names, places of work and any clients discussed. Further details are included in Part 2. There may be some rare situations in which information would have to be shared with others. As we are asking professionals about their experiences of working with individuals with psychosis related diagnoses, it may be possible that something could come up that is of concern, for example risk of significant harm to yourself or others. If this arises, I will let you know and will discuss it with my supervisor. If the concern was felt to be serious, this would lead to your line manager being informed. Data that had been collected would not be included in the study.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study at any time. As this project will be using Grounded Theory methodology, I will be analysing each interview, and using the emerging concepts to guide subsequent interviews. This means that whilst you are free to withdraw without giving a reason, I ask that you would contact me within seven days if you

wished to ensure that the data collected did not get included in the study. Following this time, any anonymised data collected up until your withdrawal would be used in the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me in the first instance and I will do my best to address your concerns. To contact me please leave a message for me on a 24-hour voicemail phone line at 01227 927070 - please say that the message is for me, Jessica Stock, and leave a contact number so that I can get back to you. You can also contact me via email on xxxxxx@canterbury.ac.uk. If you remain unhappy and wish to complain formally, you can do this by writing to Dr Fergal Jones, Research Director, Salomons Institute for Applied Psychology, Canterbury Christ Church University. Email: fergal.jones@canterbury.ac.uk

Will my taking part in this study be kept confidential?

Data from interviews will be audio recorded. The recorded conversation will be transcribed by me. I and my lead supervisor, Dr Sue Holttum, will have access to the audio recording. Data collected during the study will be kept anonymous, with participant numbers being used instead of names in both paper and electronic forms and no identifying information being included in transcripts. Electronic data will nonetheless be stored password protected. Identifying names of people and places will be changed on transcribing of interviews, and audio recordings will be erased after transcription. Any information collected on paper will be uploaded electronically and paper copies shredded. Only I will have access to the full data.

All information which is collected from or about you during the course of the research will be kept strictly confidential. The only time I would be obliged to pass on information from you to a third party would be if you said something that led me to be concerned that you or someone else may be at risk of significant harm.

What will happen to the results of the research study?

The results of the research study will be submitted to Canterbury Christ Church University, a report of the thesis will be on the University's public website and results may be published in a scientific journal. Anonymised quotes from the interviews will be used in final and published reports, however participants will not be identified in any report or publication.

If you wish to receive a summary of the research, this can be emailed to you following completion of the research.

Who has reviewed the study?

This study has been reviewed by the Salomons Ethics Panel at the Salomons Institute for Applied Psychology, Canterbury Christ Church University.

Compliance with General Data Protection Regulation (GDPR)

Canterbury Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University will keep only anonymous data for 10 years after the study has finished. Signed consent forms are kept for one year and then destroyed.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use information by contacting Deborah Chadwick who is the names data custodian for Salomons Institute for Applied Psychology, Canterbury Christ Church University on 01277 927074 or by emailing Deborah.chadwick@canterbury.ac.uk

Individuals from Canterbury Christ Church University and regulatory organisations may look at your anonymous research records to check the accuracy of the research study. The only people in Canterbury Christ Church University who will have access to information that identifies you will be people who need to contact you to audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. Canterbury Christ Church University will keep anonymous information about you from this study for 10 years after the study has finished.

Further information and contact details

1. General information about research.

If you are interested in finding out more about research in general, you may find the websites below helpful.

NHS choices overview on medical research
http://www.nhs.uk/conditions/clinical-trials/pages/introduction.aspx

NHS Health Research Authority
http://www.hra.nhs.uk/

National Institute for Health Research
http://www.nihr.ac.uk/research/

2. Specific information about this research project.

If you would like to speak to me and find out more about the study or have questions about it which you would like answered, you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me, Jessica Stock, and leave a contact number so that I can get back to you. You can also contact me via email on xxxxxx@canterbury.ac.uk.

3. Advice as to whether you should participate.

If you are unsure about participating in this study, you can contact me on the above details, alternatively you can contact me by email on xxxxxx@canterbury.ac.uk. I would be happy to discuss any questions or queries you may have.

Appendix G: Participant Consent Form

05.03.2020

Study number:
Participant identification number for this study:

CONSENT FORM

Title of Project: How do psychologists understand and negotiate the impact of the organisational context on their individual work with people with psychosis?

Name of researcher: [redacted] [redacted]

Please initial next to the following statements and sign below if you are happy to take part in this process. ☐

1. I confirm that I have read and understood the information sheet (date 05.03.2020; Version 2) provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is entirely voluntary and that I am free to withdraw without giving any reason within 7 days of the interview to ensure that the data provided does not get analysed and included in the study. Following this time, any anonymised data collected up until my withdrawal will be used in the study. ☐

3. I understand that data collected during the study may be looked at by the lead supervisor, Dr Sue Holttum. I give permission for her to have access to my data. ☐

4. I agree for the interview to be recorded and that anonymous quotes from my interview may be used in published reports of the study findings ☐

5. I agree to take part in the above study. ☐

The below item is entirely optional and will not impact upon your decision to participate in the current study. If, at a later date, you decide that you would ***not*** *like the anonymised transcript to be stored for future research purposes, please contact me before 30th September 2021 on* [redacted]*@sussex.ac.uk to inform me of this decision.*

6. I consent to the anonymised transcript of this interview being stored within the Salomons Institute data archive for use in future Salomons Institute research projects which aim to build upon the findings of this study. ☐

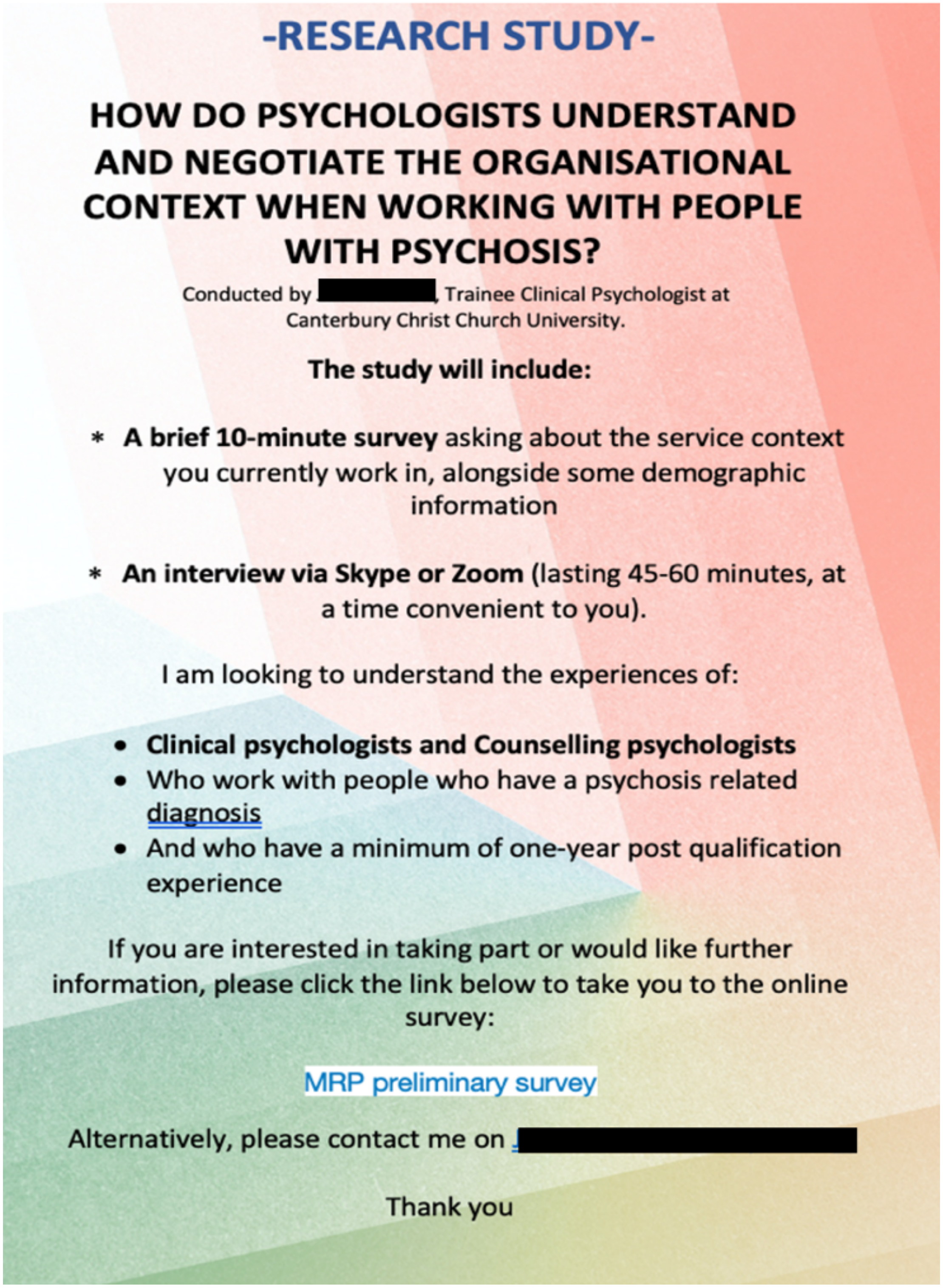
Name of Participant __________________________________Date: ________________

Signature____________________________________

Name of Person taking consent _________________________ Date: _______________

Signature___________________________________

Appendix H: Research Poster



-RESEARCH STUDY-

HOW DO PSYCHOLOGISTS UNDERSTAND AND NEGOTIATE THE ORGANISATIONAL CONTEXT WHEN WORKING WITH PEOPLE WITH PSYCHOSIS?

Conducted by [redacted], Trainee Clinical Psychologist at
Canterbury Christ Church University.

The study will include:

- **A brief 10-minute survey** asking about the service context you currently work in, alongside some demographic information
- **An interview via Skype or Zoom** (lasting 45-60 minutes, at a time convenient to you).

I am looking to understand the experiences of:

- **Clinical psychologists and Counselling psychologists**
- Who work with people who have a psychosis related diagnosis
- And who have a minimum of one-year post qualification experience

If you are interested in taking part or would like further information, please click the link below to take you to the online survey:

MRP preliminary survey

Alternatively, please contact me on [redacted]

Thank you

Appendix I: Screening questionnaire

This questionnaire was set up on Qualtrix:
https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_0lzQMFYTI5gv0Ff

Hello and welcome to the initial survey for this research project.

The purpose of the study is to explore how psychologists working across different organisational contexts within the NHS understand the work they do with people who have received a psychosis related diagnosis and to consider the potential role of the organisational context in that work. The aim is to then develop a model that captures this perspective.

If you are happy to take part in this project, please provide your contact details at the end of the survey. I will then be in touch by email to provide you with the full information sheet and consent form. I am also happy to answer any questions you might have about the project.

Training Background	
Where did you complete your training?	
What year did you complete your training?	
What is your predominant therapeutic orientation (e.g., psychodynamic, CBT, integrative)?	
Service Context	
What is the current service context where you work?	
How long have you been in your current post?	
Have you worked in any other service context with people with psychosis related diagnoses?	
How long have you worked with people with psychosis related diagnoses	
Which geographical region do you work in?	
If you are happy for me to contact you, please provide your name and contact details	
Name:	
Contact details:	
Age:	Ethnicity:
Gender:	
Would you be willing to say something about how you feel the service context affects your work with clients?	

Appendix J: Interview schedule

Version 2 10.09.2020

Question development marked in red

Interview Schedule

Hi ******* thank you for agreeing to speak with me. Is this still a good time?

Ok, so as I am sure you remember from the information sheet, the purpose of my study is to **explore how psychologists, working across different organisational contexts within the NHS understand the work they do, with people who have received a psychosis-related diagnosis**,

and specifically **consider the potential role the organisational context has on the work**

You have been invited to participate as you are a psychologist currently working with individuals who have received a psychosis related diagnosis.

Do you have any questions at this point?

I have prepared an interview schedule which has 4 main sections, and the interview should take between 45 minutes and 1 hour. Please let me know if you need to stop or take a break.

Also please remember that you are able to refuse any question without giving a reason.

Ok, if it is ok with you I am going to start recording!!

1) Current work:

Prompt: If you work at two different service contexts, please can you choose one to discuss.

Could you tell me about the services that you work in as a psychologist- briefly - what is your week like? And in terms of what kinds of clients you normally see?

a. Context and typical week:

b. Can I ask a little about the demographics of the clients that you see: Age? Diversity? Gender? How typical is that of the caseload or you caseload.

c. How typical is that in terms of what it is like?

d. Has it changed over time or has it remained the same?

e. [If working in different service contexts] How is that different from your other service context?

2) Service contexts:

Prompt: If you work at two different service contexts, please can you choose one to discuss.

a. What kind of ideas or philosophy do you feel that your service adopts?
    - Prompt: Whatever that means to you/ feel free to interpret the question in any way you feel.
    - Prompt: Are there some situations where that is more prominent, or less?

  - Are there other ideas or ways of thinking you experience around you in the service?

b. How do you feel these ideas/ways of thinking might affect the work that you do with people with psychosis?

  - Prompt: e.g., in team meetings and clinical meetings?

c. Has there been any shifts more generally higher up in the in the organisation/ trust that has impacted on your experience of the service or the work?

d. In what ways do you think they affect your own relationship with the service context?

  - let's think about a few situations where your relationship with the service context becomes relevant, for example

  - thinking about places and encounters where you are directly faced with those philosophies how do you feel about it?

  - It sounds like it is helpful? What is helpful? Anything unhelpful?

e. How do you understand your role as a psychologist within this service?

f. [If working in different service contexts] How is that different from your other service context?

In this next section I will be **asking about different pieces of work that you have done** with people who have a psychosis related diagnosis. Please feel free to use pseudonyms and know that in my transcriptions that I will change any identifiable information related to you and your client.

3) **Example of someone doing well in each service and how your skills may have contributed**:

Prompt: If you work at two different service contexts, please can you choose one to discuss.

Can you give me an example of someone who came with a diagnosis of [psychosis/schizophrenia] and who seemed to benefit from psychological therapy?

a. Could you describe the changes you saw in this person – perhaps how they seemed to be functioning in their life when they first came, and how they were functioning later on?

b. What do you think it was about what you did or what happened over time in the therapy that you think led to this person's improvement?

c. Was there anything about the service/ organisation that supported your work with this person?

d. Was there anything about the service/ organisation that you feel made it difficult to work with this person?

  - Prompt: Tell me more about that/ How did you deal with that?

4) **Example of someone not seeming to benefit and your understanding of why not/ what might have helped:**

Prompt: If you work at two different service contexts, please can you choose one to discuss.

Can you think of someone who came with a diagnosis of [psychosis/schizophrenia] and who **did not seem to benefit very much** from psychological therapy?

a. Could you describe how the therapy played out for this person?

b. [If needed] It is not always easy to work this out but were you able to get a sense of **why this person was not able to benefit much**, or p**erhaps what might have been helpful to them**, if anything? Prompt whether would like to say more.

c. What was it about the service/ organisation, if anything, that you feel was useful when working with this person?

d. What was it about the service/ organisation, if anything, that you feel made it difficult to work with this person / diagnosis?

  - Prompt: Tell me more about that/ How did you deal with that?

5) In addition to some of the things you have already mentioned, **is there anything about the [different] organisational contexts that you have experienced that you feel has played an important role in being able to work beneficially with people with psychosis related disorders?**

6) **Anything else you would like to say?** That is all the questions I had, but there may be something you would like to say that I have not touched upon.

Or Is there anything else you would like to say about what helps your practice with people with this diagnosis?

Ending:

- Turn off recording and state that this has been done.
- Offer a chance to debrief- How did you find that?
- Can I check that you are happy with how the interview was conducted?
- Thank you very much for taking time out of your evening to speak with me

Do you have any further questions? If anything occurs to you in the next few days – just anything you are not sure about or if you want to check anything out with me, do get in touch.

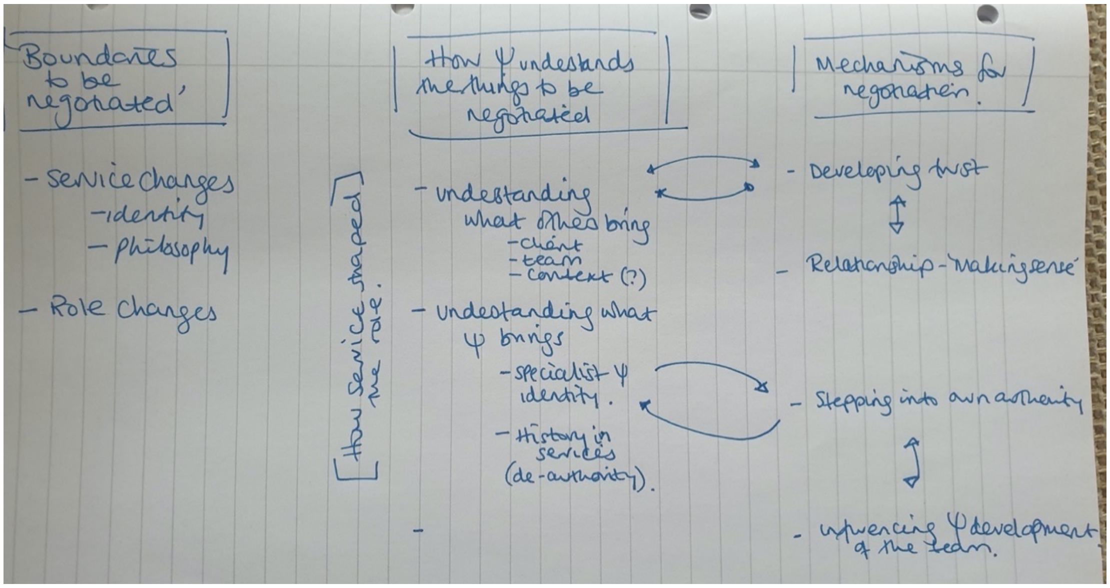
Explain access to the findings (I will send a summary of the findings to all participants. It will be submitted for publication by December 2021 and hopefully published by 2022)

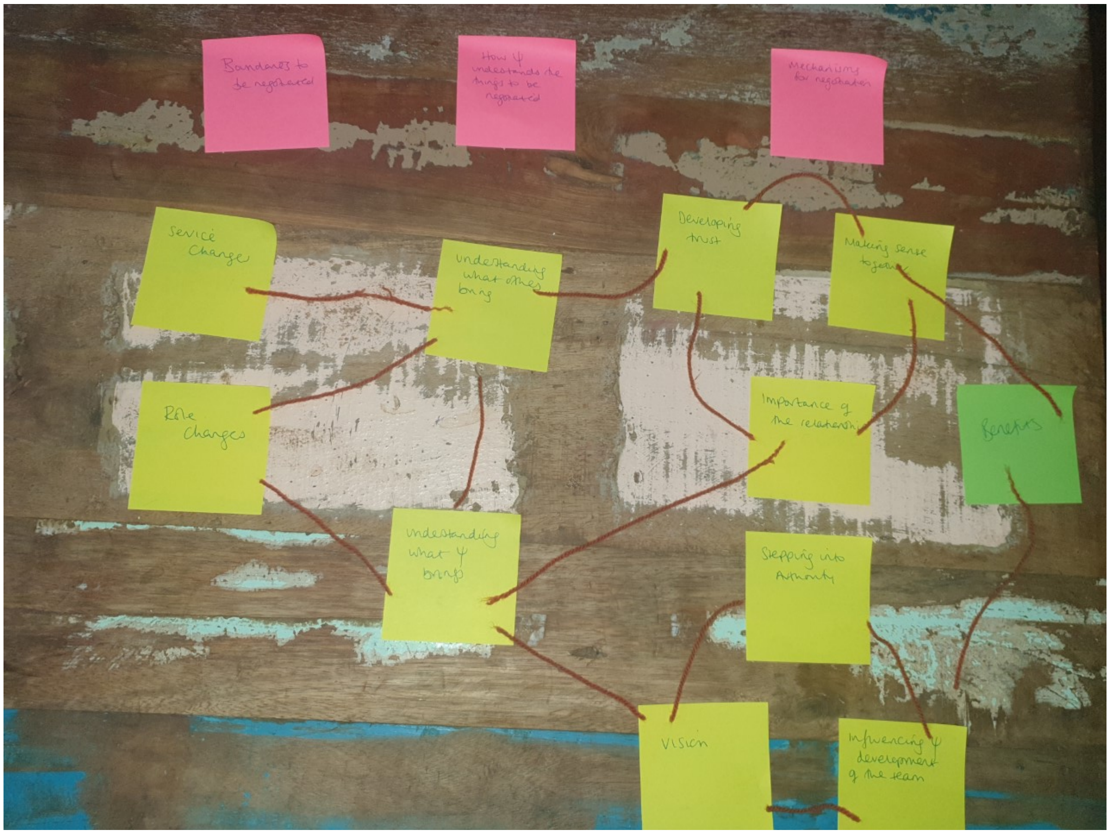
Would you be open to me contacting you later in the project if there were further questions that might be useful to ask you as the theory develops?

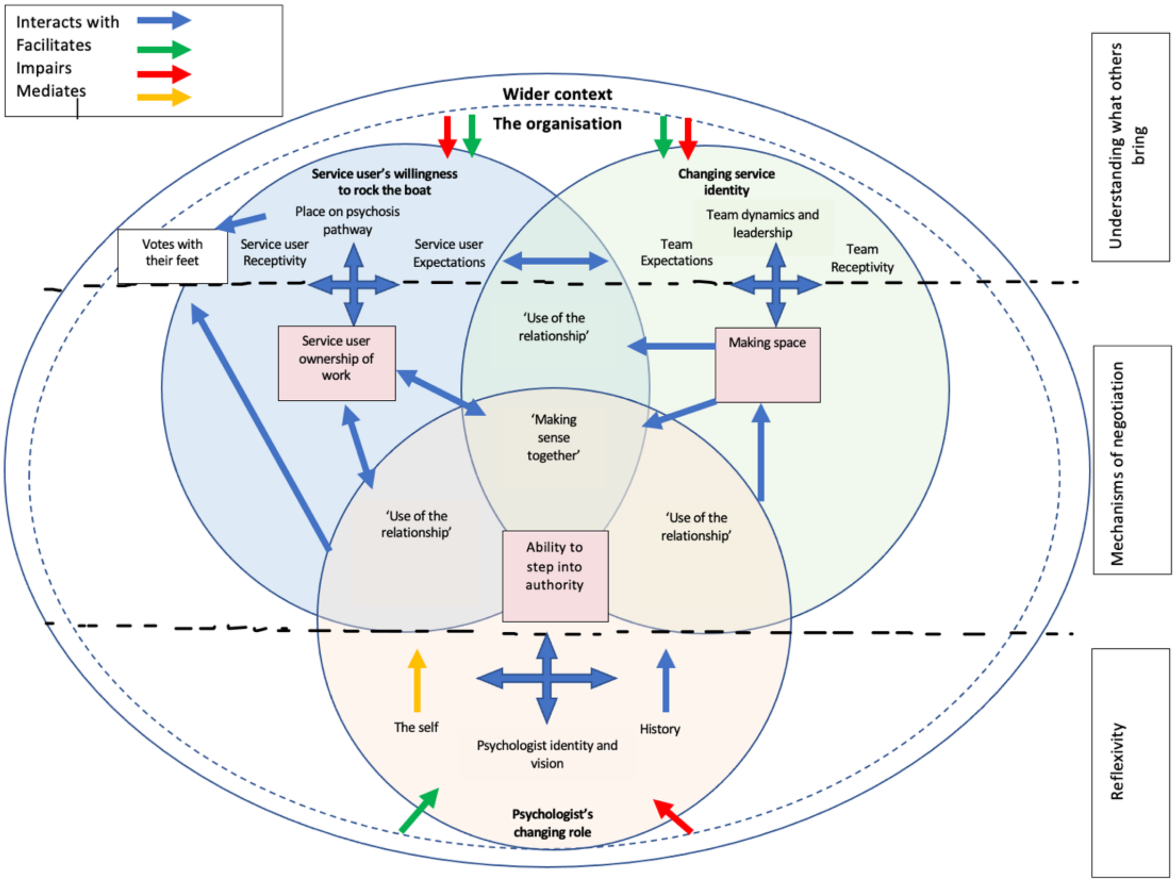
Respondent validation: Would you be interested in commenting on a brief summary of the findings via email around January 2021? This is to ensure that participants feel we have accurately represented their experience.

Thanks again and goodbye

Appendix K: Model evolution






Interacts with
Facilitates
Impairs
Mediates
Wider context
The organisation
Service user's willingness to rock the boat
Place on psychosis pathway
Votes with their feet
Service user Receptivity
Service user Expectations
Service user ownership of work
Changing service identity
Team dynamics and leadership
Team Expectations
Team Receptivity
'Use of the relationship'
Making space
'Making sense together'
'Use of the relationship'
'Use of the relationship'
Ability to step into authority
The self
History
Psychologist identity and vision
Psychologist's changing role
Understanding what others bring
Mechanisms of negotiation
Reflexivity

Appendix L: Bracketing mind map

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Appendix M: Positioning Statement

Both the bracketing interview and the bracketing mind map helped me to develop my thinking about the beliefs I hold about the role of psychologists within psychosis services, and how these assumptions might impact on the interviews and analysis.

I am a white British female, aged 30 at the time of embarking on the project. Since finishing my undergraduate degree in 2009, I have worked in many services that fall across the ‘psychosis pathway’. I spent a number of years working in supported housing projects, where I observed people often caught in discourses of chronicity and limited possibility for change. Many of the people that we were supporting had horrific histories of trauma and continued to experience significant distress. This distress was often met with policy-led strategies and emotional distance from staff. There was a sense within the staff team, that our role was predominantly to maintain the level of wellbeing, achieved through medication management, rather than promote meaningful connection. This is when I first became interested in the role of both the organisational context and its culture on professional helping relationships. I became aware of my frustration at how professional discourses can interact to maintain disconnection, isolation and social exclusion for people with psychosis-related diagnoses.

The role of the organisational context in shaping professionals’ attitudes was brought again to the fore through my later experiences within ‘psychosis’ intervention research, and Early Intervention Services. To me, these contexts held a sense of energy and possibility that appeared lacking within other contexts. My experiences within these services felt more hopeful. The role of staff appeared to be about providing opportunities for people with psychosis-related diagnoses to take an active role in shaping the support they need.

Throughout all my experiences, maximising the meaningfulness of the professional helping relationship has always been an area of interest. In developing this project, I wanted to think about the therapeutic relationship, but also consider how the organisational context and culture interact to shape and guide what is therapeutically possible. The bracketing interview was incredibly useful in helping me to think about the interviewing relationship, and the kinds of attributes I may be drawn to in participants. This also brought to awareness an expectation I held that all psychologists working across ‘psychosis’ services would have similar values to me. It helped me to consider how I will need to be in interviews to also enable psychologists to bring views and values that I may not hold.

Appendix N: Abridged Reflective Diary

The following are excerpts from my reflective diary which have been selected to demonstrate my own interaction with the research process.

23.03.19

I met with the service user consultant group today to discuss my project and think about what factors I may need to consider when speaking with my professional participants. It was quite a large group of people, and I had a relatively small slot. Although it was a little intimidating, it was really useful to have the opportunity to explaining my project outside of discussions with my supervisors. The consultants were interested in considering therapy as a relationship and understanding the other factors that the psychologist brings in with them into the room. It was particularly helpful to talk about the potential areas to explore when developing interview questions, (including how did the psychologist know there was a good outcome? Would the service user agree with them? Were psychologists aware of any particular things impacting on therapy at any time?) I will think with Sue about how I may develop open questions which may enable these areas to emerge without being too leading.

13.05.19

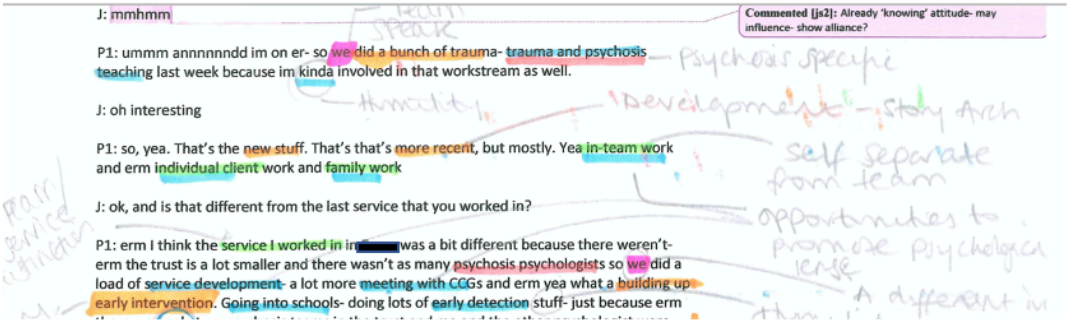
I have been reading more about grounded theory and leaning towards Charmaz's constructionist approach which explicitly recognises the researcher's role in the construction of the data. One of the initial reasons that the idea for this project came about was that Sue had recently finished a similar project looking at how art therapists understand their work with people with psychosis- related diagnoses. Following discussions with Sue, it emerged that the treatment context often mediated what the art therapists felt was therapeutically possible. It was this that made me want to foreground the organisational context in my research. This shift in focus from being a replication with a different professional group, to foregrounding the role of the organisation felt a positive move. It will be important to hold Sue's project as a sensitising theory, although make sure that this does not impose upon the work

10.04.2020

While transcribing my first interview I became frustrated with my interview style at times. I became aware early on that the participant wanted to be helpful- checking and clarifying whether their answers were what I wanted. I was aware of my role as a trainee psychologist and that my participants would likely have been in a similar position to myself, which may have influenced their wanting to be helpful. I did also wonder if it was reflective of a psychologist's training in seeking feedback. Throughout the transcription, aware of my established knowledge through my own experience in mental health services, I could see times where I may have 'known' too quickly (for example, when the participant said: 'so they don't get medical modelled' and I replied 'mmhmmm'). I think this is probably a good example of why holding a social constructionist approach is appropriate with this project, as it shows that there is a level of co-constructing that is being done throughout. On re-reading Charmaz's chapter on inventive interviewing it will be important to draw out more around what participants mean by statements, rather than assume this knowledge.

19.05.2020

I began coding my initial manuscripts today. On paper. With highlighters, pens and pencils. I became aware (and a little overwhelmed) at how many directions I could take with the coding. I think this way of coding felt a little unstructured, and I found myself moving away from the data too quickly- for example there was already a sense of a 'story arc' or service development journey ('new stuff', 'more recent', 'building up'). I found this way of transcribing really useful in familiarising myself with the data. Doing this word-by-word level coding, there was a real sense that how the psychologist positions their self within the team was important. However, this method of coding would not be considered systematic, and not easily able to discuss remotely with Sue. It was at this stage I returned to reading Charmaz for more guidance through the coding stage.



J: mmhmm

Commented [js2]: Already 'knowing' attitude- may influence- show alliance?

P1: ummm annnnnndd im on er- so we did a bunch of trauma- trauma and psychosis teaching last week because im kinda involved in that workstream as well.

J: oh interesting

P1: so, yea. That's the new stuff. That's that's more recent, but mostly. Yea in-team work and erm individual client work and family work

J: ok, and is that different from the last service that you worked in?

P1: erm I think the service I worked in in [redacted] was a bit different because there weren't- erm the trust is a lot smaller and there wasn't as many psychosis psychologists so we did a load of service development- a lot more meeting with CCGs and erm yea what a building up early intervention. Going into schools- doing lots of early detection stuff- just because erm

10.07.2020

Yesterday was the day I tweeted my research website. A lecturer at Salomons had advised me throughout the website development and I am happy with the final product. I have never made a website before, so this was a new skill. This lecturer, who has a large following within my research area, retweeted my website. I have to say it was terrifying and addictive to see how many times people then retweeted or 'liked' the project. It made me think about my use of social media, and how this was the first time I had put myself 'out there' in public. Given my difficulties with recruitment, it was astonishing to think that this one tweet was so important for me and for the success of my work. Off the back of this tweet and those who extended it out through their own networks, I have had a further 18 people complete my initial survey registering interest! This sudden burst of recruitment, alongside difficulties with finishing transcription, has meant that the theoretical recruitment that I had hoped to develop will not be possible and I will have to consider a modified GT approach. I am disappointed and frustrated with myself for being in this position, but equally feel that I am doing what is within my capacity at this time.

31.07.2020

The speed at which this interview followed the last was really useful, it allowed me to develop and expand in areas (like the psychologist's self) that emerged as important in the last interview. This interview really highlighted for me the size of the task faced by psychologists in some services. Psychology felt like a small cog tasked with implementing change in a service which has a very medical understanding of difficulties. This was by far the longest of all my interviews. I did wonder about why this might have been afterwards. I felt more comfortable in this interview, which made me think back to my initial bracketing interview and the attributes may I be drawn towards. This participant was female and around my age, although there were a number of other areas of difference. I wonder if this had potentially enabled me to feel more at ease, again bringing into consideration the role of me as the researcher and how I am co-constructing this data.

07.08.2020

I met with Sue for research supervision today and gave an overview of my most recent interviews. Sue had some really interesting thoughts on the areas that could be explored. We spoke about how the discussion of race and representation was not emerging from the interviews, and whether this was a reflection of the areas in which participant's services are located, or to do with people not being referred, or another reason. I wanted to include a question which would enable participants to discuss this, which was supported by Sue.

01.10.2020

Today I spoke with the person who had been working in services for most 20 years. I was incredibly grateful for the opportunity to speak with someone who was able to provide a history of service developments over this time. One of the things that this person highlighted was the retreat to traditional models at times of instability or scarcity. This again highlighted to me the importance of organisational infrastructure, and the fragility that comes with services for people with psychosis related conditions. What was really interesting was that when asked about somebody who had benefited from psychological therapy, they chose to talk about somebody from when they first started working. I think that the participant talking about this person demonstrated how different people stay with you. I think the person he described may stay with me also, particularly when thinking about who treatment is for (in the case of this client, the medication she received served to reduce the discomfort for the staff but left her alone with her distress but unable to express it).

05.12.2020

I am finding the MRP part A to be quite difficult. There are so many different parts that I want to write about, and I worry that I am going down too many rabbit holes. What I am finding is that writing this is enabling me to reconnect with the psychological positions of 'psychosis' and is giving me an opportunity to learn a lot more about the historical, social and political context surrounding the development of the concept. In researching the different aspects, I realised how many decisions I would need to take in terms of definitions, positions and critiques. I think that writing the Part A will speak to the values that I hold. This is where my choice of using a social constructivist epistemology will be invaluable as it positions me as the analyst and enables me to be within the data. I am hoping that the strength of feeling that I am hopefully portraying in the Part A will go some way to reinforcing the need for considering the interactions with the organisational context.

19.03.2021

In meeting with Sue, it became clear that I needed to return once again to my fractured data.

I explained that once again I was struggling with the methodology and found myself imposing codes on multiple interviews rather than allowing the iterative changes to emerge. I am satisfied that my gerund codes reflect the data well, and so I let go of the selective codes and returned to my open codes where the fractured data was still held at the social action stage. I went through and grouped these into 12 distinct sections. To attempt to prevent a repetition of my previous coding endeavours, I took this one stage further at this point and grouped the 12 categories into 5 main themes: Negotiating changing boundaries; influencing the psychological development of the team; Understanding what others are bringing; Use of the relationship and its benefits; Organisational enablers and disablers. It was at this point I started to use the theoretical memos to start to interrogate the themes and begin to map out relationships.

29.03.2021

Following yesterday's moment of clarity in organising the emerging model, I spent the first part of the morning looking more into theories of negotiation. Interestingly, there was an emphasis throughout on creating a shared understanding of the context and the conflict. However, negotiations always have an aim. While my model thus far may break down into phases of negotiating, it lacks awareness of the impact of the wider context and a direction or purpose for negotiation. Throughout my interviews the main goal or outcome is about 'improving services for people with psychosis', this is explicitly stated by some. This is what the evolving model is missing.

30.03.2021

I'm trying to think further about the initial category 'boundaries to be negotiated'. I want to think more about 'the boundaries of the role'. It seems to me that the freedom to define the role was related to the ability to step into authority. It was also related to influencing the changing service identity (e.g., becoming trauma-informed rather than leaning towards a medical model). A systems psychodynamic lens appears to be quite seductive at this stage, and I will need to be actively working to ensure that the model continues to emerge from the data. I recognise that I keep getting pulled into different participant's arguments- particularly around the 'illness narrative' and how that can lead to expectations around therapy, the avoidance of thinking about distress through medication- thus limiting people's willingness to rock the boat (or to willingly destabilise themselves). These are interesting to consider, but the model needs to answer the research question. Many see psychology as a part of the MDT rather than replacement of a dominant model. Many of the participants recognise the need for a coherent narrative (which would involve concessions from both the medical approach and the psychological alternative). This helped me to think more about the category ‘making sense together’ and how this was the intention both with clients, but also with the team.

06.04.2021

Today I went back through the last iteration of the model, clarifying and thinking through areas that require development or further explanation. I did this alongside the chapter by Thornberg & Charmaz (2014) as this held questions I could ask and gave me confidence in continuing with the model I have laid out. The number of times I have organised and reorganised my data has at least provided me with a thorough grasp of my first 6 interview transcripts. The emerging Venn diagram captures at least some of the interacting complexity that I hope to portray, but it also highlights areas that require more development and organisation. I am finding the shift between coding, diagramming and explaining the diagram useful. What I am worried about with the diagram is the loss of some of the emotion that was in (most) participants accounts. This was the sense of challenge, the frustration, the fragility, the need to fight, the sense of injustice that comes with being a lone voice. Is this missing from my diagram because I am not centring it? Or is it not pertinent to the research question at this higher level of abstraction?

Appendix O: Excerpt from an Open-code Transcript with initial memos

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Appendix P: Example of a memo during theoretical coding

11.04.2021 I have combined ‘awareness of what the client is bringing’ with ‘willingness to rock the boat’. I had initially kept the ‘person’ separate from the ‘psychologist’s awareness of the person’. This was initially quite useful as it helped me keep the participant’s actions in mind, however in practice all categories are seen through the co-constructed research lens. Keeping these separate added a layer of complexity that detracted from the model, but it is necessary to think through to ensure that nothing gets lost in merging these groups. Participants all emphasised that many people within the ‘psychosis pathway’ have experienced considerable trauma. Reports were particularly notable at later parts of the service user journey. Participants recognised that often people may not be in a place where they are ready or wanting to talk. **‘Willingness to rock to boat**’ (directly stated by two participants) described how service user’s whose unusual experiences may be ‘dampened’ or managed by medication were reluctant to engage in psychological therapies which may require talking about distress. **‘Willingness to rock to boat**’ seemed to me to capture three inter-related factors that psychologists needed to be thinking about in navigating work with people with psychosis-related diagnoses

Place on the ‘psychosis’ pathway: Where the client is on the service user pathway (point of entry, history in other services)

- Having a negative experience of services
- Service for people struggling with first episode
- Our service doesn’t see those clients
- Recovering from being in crisis
- Who gets seen within service?
- Working at the other end of the psychosis spectrum
- Secondary care clients are complex
- Working with people who have experienced trauma
- Client felt services had harmed her
- Length of therapy reflects time spent unwell

These are examples of the focussed codes that were used to form the subgroup ‘place on the ‘psychosis’ pathway’. I have selected these codes as they each have fuller quotes attached, (although all participants make some reference to the people they see and the difficulties they may have as often as a result of being unwell for a long time). Each of these examples indicate that service users all have some level of history (little-to-extensive) with mental health services. This is of course to be expected in sampling participants working across the service user pathway, but it highlights a ‘spectrum’ of experiences which often relate to length of time needing the support of mental health services and how previous experiences may shape interactions.

12.04.2021 This category has changed a number of times over the evolution of the model. A number of the focussed codes appeared related to ‘avoidance’ and the understandable need to try and avoid distressing experiences. However, while this captures some experiences, it lacked some of the relational aspects (relationship to experiences, relationship to power, relationships to safety).

- Some clients prefer cannabis to talking
- Wanting to use own management strategies
- Considering readiness for therapy
- Are they in the right place?
- People can't bear tolerate or buy the rationale
- Trying again at point of crisis
- I don't want to rock the boat
- People don't understand what psychology is
- Power dynamic impacted receptivity
- Difficulties when people choose not to think differently
- Spotting when people are not able to reflect

When working with people with psychosis, participants discussed being aware of needing to navigate the client's own interpretations and relationships to their experiences. A client's willingness to consider alternative perspectives is an important factor to consider. This felt better captured by the term '**receptivity'.**

Client's receptivity to engaging in a psychological intervention was often discussed when thinking about clients who do not benefit.

13.04.2021: Merging 'awareness of what the team brings' with 'changing service identity' required a lot more thought and reorganisation. I think my difficulty has been in separating out when people are talking about 'the team' and when people are talking about 'the service'.

For example, P2 has both changes to the dynamics of the team (new leadership, new members) but also has a new service philosophy, which the team are struggling with. Other participants sit across a number of teams but sit within one service. They are two distinct things. However, when looking at negotiating dynamics, participants talk about the people they are working with, rather than ways to negotiate the (often imposed) changes to the service. Rather than changing service identity, I will move 'service related' content (including organisational change/and changes to philosophy and values) to aspects of the organisation and keep this section more about navigating team dynamics.

Initially a sub-category termed: 'team dynamics and leadership', I have moved team dynamics to a higher-level code. Eight of the 14 participants spoke about team dynamics, thinking about/ being aware of/ navigating. The term 'dynamics' was used, but so were group or team processes.
One participant spoke about needing to have 'one foot in and one foot out of the team' to enable reflection of the team dynamic. I was initially wondering whether this would be a good in vivo quote to represent this category, however I think it has more to do **with 'making space'** and represents a mechanism that enables awareness rather than an awareness of dynamics.

Appendix Q: Abridged coding table for 'Navigating a complex system'

Domain	Core category	Subcategory	Focussed Code	Supporting quote
Navigating a complex system	Service user's 'willingness to rock the boat'	Place on the 'psychosis' pathway	Having a bad history of services	...our client group are a people who have quite often dropped out of services, have bad history of services (P2)
			Who gets seen	And I was like yep, I suppose similarly the people that experience a psychotic episode who haven't experienced a trauma, probably have an episode, stabilize, and we don't see them in our service anymore. I don't think the patients that we see, are those. (P6)
			Clients are complex	So, they're all very complex. Not all of them, but lots of them in secondary care have really complex presentations and histories (P9)
			Working with traumatised people	I guess, yeah, people have experienced lots and lots of trauma usually and have then committed an offence that's led to them being in the criminal justice system (P10)
			Services had harmed her	So, this is a kind of an ongoing source of antagonism, with services, I guess, in the sense that they had harmed her, which in some sense, we had undoubtedly harmed her some of this, but, but also this very specific problem. So that was a, you know, that would be a kind of a recurrent source of difficulty (P11)
		Service user's receptivity	People can't bear, tolerate or buy the rationale	So, definitely with psychosis clients, it's that people just can't bear it, just can't tolerate it or don't buy the rationale. So, the idea we've got to look at this now- they are like No. No, I don't want to or just, yeah. Don't want to face it- the trauma. Don't want to think about the trauma. Don't want to face it, yeah. Those are the people who don't do well, can't really benefit if they're stuck in that place (P5)
			Trying again at point of crisis	...relapse is a time of time of crisis- **they're like they're prepared to rock the boat cos the boat's already been rocked kind of thin**g. So, then that will be the time at which we're like come on, you know, let's see if we can do some work now. Yeah. But it's the clients that kind of seal over and are super avoidant and think that avoidance is- avoidance is clearly the best way to handle this and I'm mental suggesting anything else kind of thing. (P5)

			"I don't want to rock the boat"	And he was a bit like 'yea alright then' really ambivalent-so we had a go and we have met a couple of times and he's really in a place where he's like 'I'm all right at the moment- so, why would I want to talk about anything? Because I feel alright. **I don't want to rock the boat**' (P6)
		Service user's expectations	Expecting EI to be the same	So, yea. I think those that experience for her was hugely unhelpful, massively retraumatising and erm got her off on the wrong foot with us, I think. She kind of expected us to be the same and we are trying really hard not to be. (P1)
			Expecting therapy to treat symptoms	They might think that therapy is gonna treat something to do with symptoms- when actually the therapy might not really address that as well. (P3)
			'You are going to be ill forever'	A lot of people have been told things like, oh, you're going to be ill for the rest of your life (P9)
			Expectations differ for different cultures	Or maybe you're more likely to, to not ask for something like psychology, maybe not to expect it or not to think that that's something that could be helpful for you or it's not part of your cultural or family, sort of in your awareness of what you understand can help in the these with these, kind of, situations (P14)
			Change is threatening	...someone who again, has a really long history and I think was probably an in-patient in like the 70s or the 80s, in a time when things were really different and similar to what I mentioned earlier, I think experienced the idea that anything could change as being quite threatening (P14)
		Voting with their feet'	Prematurely endings	I think the ones who don't benefit are more- aren't necessarily going to be on my caseload for long- you know they are going to sack me, or the therapy ends. (P2)
			People vote with their feet	I think with this group often when therapy doesn't work out er there is this it element of **people voting with their fee**t and sometimes they'll be sort of people well will stop coming or will disengage with me or with the service, and that's one way of sort of understanding therapy is not working for that person (P3)

		Therapy not beneficial	I mean, I suppose that the, I mean, I guess the most, I mean, the most obvious example would be somebody who wouldn't be or somebody where there was a real engagement problem. I mean, although these would often be quite short stories. So, I suppose that somebody I might have seen a couple of times and, and then they'd refused to see me again (P11)
		People not ready	Usually when it's not worked out, it's often it's because they're not quite ready (P13)
Team dynamics	Leadership	Personalities are key	So, as I said, often- on an operational level that is far more personnel driven than its kind of organizational principles (P4)
		Team trying to survive	They were very hampered for years by a really awful psychiatrist erm who was just a horrible person and racist and sexist, misogynist, as well as really adhering to a medical model erm … You know, if they tried to bring in understanding the person or persons experience, they would literally get laughed at and like humiliated in team meetings... So, I think they're, so I thought that philosophy that philosophy of that time was kind of survive and get through kind of thing and how to challenge this yea awful practitioner. (P5)
		Experience depends on psychiatrist	So, erm it's sad that this is still the case, but I think it is and is in my work anyway, so one - so, I think sometimes it depends on the nature of your psychiatrist that you work with (P6)
		Team felt unsafe	But one of the problems being that we had a very difficult consultant, and she was very, very hierarchical and she would quite often throw her weight around and it led to quite an unsafe feeling in the team. That's to express how you felt, I think, or to express any anxiety, was to express some kind of weakness that she may capitalize on later on. So, sometimes it's felt quite unsafe, I think, with her around (P7)
	Team expectations	Expectations about therapy	The expectations from therapy and maybe when a when a culture feels more of medically dominated, how therapy might sometimes be talked about in a way that might position it like- you know it often gets described as an intervention and then there might be an expectation that it would erm pr- produce some sort of result, or it- or I as a therapist might then offer some sort of solution (P3)

		Expectations from historical experience	I think for a long time and it's old, but psychologists were a team that kind of inputted and it was one to one work- cos that’s how historically psychologists did used to work erm but obviously we were all training and little bit different. So, erm yeah, I guess it’s, you know. So, people to kind of catch up with that and for us to promote that that might be helpful (P6)
		Psychology is to ‘sort out the rest’	I think partly as well, like psychology can be viewed as like, a, okay, we've done the medication bit. what are you going to do, to sort out the rest? (P10)
		Holding magical expectations	I think people, people assume that I'm going to come in and this person is going to interact completely differently with me or I'm going to have some magic wand. I'm going to be able to get them to do something completely different. And maybe people see it like that, that sometimes I can. (P13)
	Team Receptivity	Reception dependent on personnel	I think we have a role as a profession to be promoting that other side of the coin, which some are very open to, some aren't. It depends on the audience really. So, the ward I work on specifically, it's a erm a very MDT orientated psychiatrist who is very interested in hearing my take on someone's presentation. Erm and there's no conflict in that, but I don’t think that’s the same on the other ward necessarily (P4)
		Ideas alien to others	…you say some psychological ideas to non-psychologists, it can sound a bit strange beca- And it would sound strange because other trainings don't think about a person's context, let alone a person's history (P6)
		Team had no interest	The team I worked in, I would say was not very reflective, so they had no interest in any kind of reflective practice, they had no interest in really connecting as a team at all, around feelings. Apart from the feeling of anger (P7)
		Depends on if psychology is valued	It depends on individual practitioners, how much they value psychology or want to sort of think about the psychological approach with their clients (P9)
Adapting to organisational change	Constant reconfiguration	Transforming back to CMHT	So, they have been exclusively psychosis teams for the whole of my time there. At the moment they’re transforming, and they've become, and they are going back into being CMHTs erm so we’re just on the cusp of that right now (P5)

			Investing in psychology changed EI	I think that's probably what changed things a lot with just having more money, that we wouldn't have to be selective about who, who, we took on as psychologist, the expectation would be that we would see everybody (P7)
			Returning to the problem	All of that expertise, I think is gone. And it's just going be amalgamation and we're just going to go back into the problem. (P5)
			Limited attention span in services	We have a habit of having kind of fairly limited attention span within services. So, you get you know, you get one new initiative. That everyone is behind for a while and then and then something else comes along and, and it sort of pushes that, that, that, that idea out and then something else will be, will be what people are thinking about. So, I think it has been a, there have been elements of that going on. (P11)
		Shifts in ideas	Trying to be more accountable	Making sure we meet NICE guidelines erm for for all of our people rather than just hoping that we do. Erm so our service is really starting to be oriented to being much more accountable and evidence based and things like that so that's that's also new (P1)
			Moving towards a trauma-informed approach	We are moving towards a more trauma informed care approach, which is great. I am hoping this takes off a bit more. So yeah, they are the, they are meant to be the kind of underpinning philosophies, really, behind the service. (P10)
			Team struggling to sustain ethos	I think sometimes we, that the team struggling to sustain that and perhaps maybe struggling it to sustain it when, when times are more difficult, um, and probably, probably less, I think, I think when we start off the team was quite focused on trying to avoid an inpatient admission and or to minimize those where possible, not, not to, whereas now I think there are times when it feels like people take that option quite readily (P11)
			Identity has shifted with psychiatry	It's evolved over time and, I think, it's sort of shifted a little bit, in terms of, you know they didn't have a psychiatrist for years. The psychiatrists when they came on board a couple of years ago, which I think is kind of shifting things a little bit in terms of who is accepted and who isn't and I feel, I mean, I think there's pressures from all over, but it feels like there's a move towards - how can we not accept this person, whereas my sense is from the early days was that if anybody would be accepted (P12)

Appendix R: End of study summary for participants

HOW DO PSYCHOLOGISTS UNDERSTAND AND NEGOTIATE THE ORGANISATIONAL CONTEXT WHEN WORKING WITH PEOPLE WITH PSYCHOSIS-RELATED DIAGNOSES?

Dear Participant

Thank you for taking part in this study. The research has now been completed and the following is a brief summary of the process and findings.

The study

Fourteen psychologists working in services across the ‘psychosis’ service pathways were interviewed. Participants were located across the UK and had a range of experience working in services with people with psychosis-related diagnoses. A constructivist grounded theory methodology was used to construct a theory anchored in the accounts of those interviewed. All interviews elicited rich and insightful data, and the theory developed is just one possible way of making sense of what emerged and its relation to the organisational context.

The model summary

This grounded theory seeks to illustrate the processes that psychologists, working in services across the ‘psychosis pathway’, use to negotiate the organisational context. Findings were constructed into three domains: “Navigating a complex system”, “Stepping into authority” and “Influencing change” A diagram of the model is presented below, alongside a brief summary. Each part will then be described in turn. I would be grateful if you would then comment briefly on how much:

1. You can see your own experience (or not) within the model;
2. You can see anything major missing from the model;
3. Anything else that occurs to you that feels important to say.

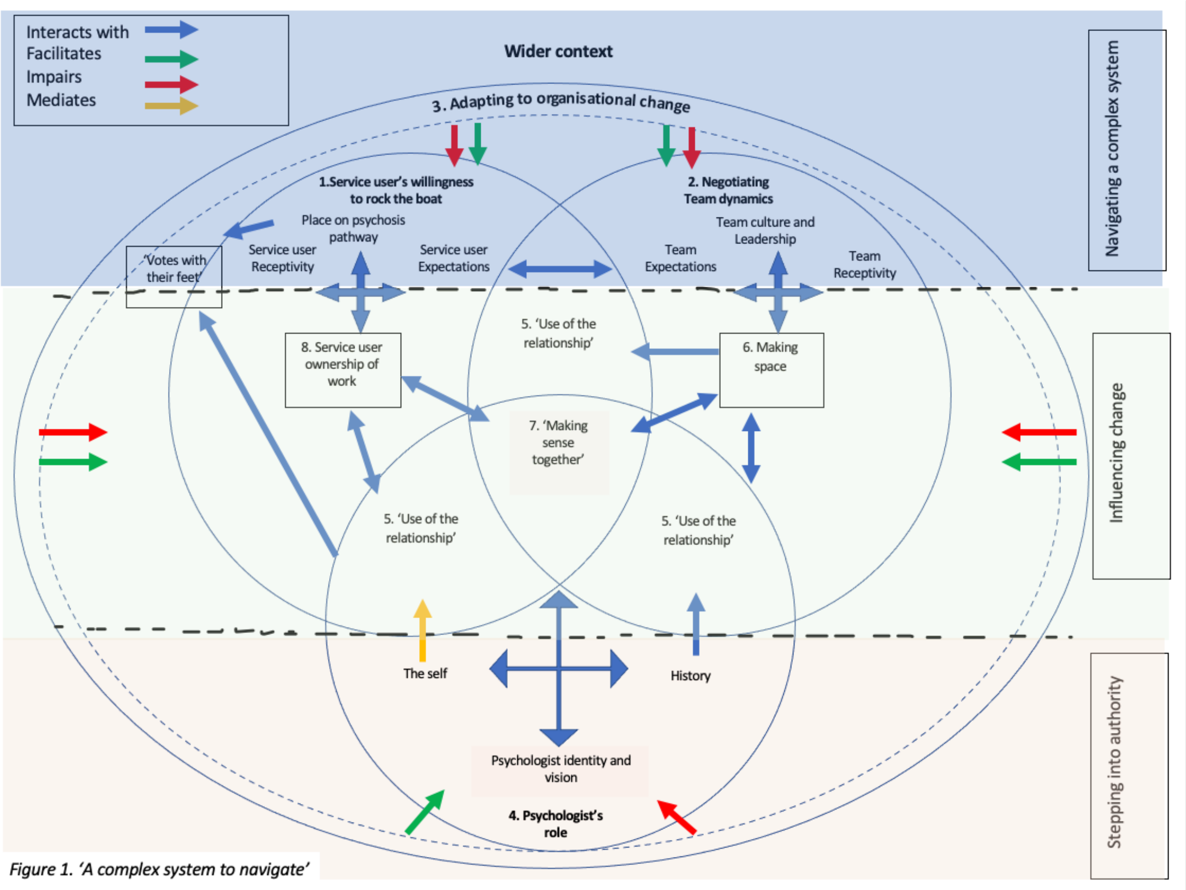

Figure 1. 'A complex system to navigate'

Summary

The emergent theory recognises that navigation of the organisational context is enabled through psychologists' holding an awareness of the multiple interacting forces that impact on their work at organisational, team and individual levels. Psychologists' awareness of themselves in their role and the extent to which they hold a vision for change has implications for how they directed their influence. While constrained by organisational infrastructure, participants' perceived authority to create spaces within the service was mediated by their relationship with the team. Within these spaces, participants could offer the team containment, supervision, and could model compassion (to a greater or lesser extent), thus reinvigorating (where possible) team relationships with service users. These spaces further enabled the bringing together of multiple perspectives cocreating a coherent understanding of service users' difficulties.

At the heart of the theory is 'Making sense together'. Creating opportunities for the team to make sense together better enables communication of a consistent message to service users. This then has potential positive implications for service users' expectations for, and receptivity to, psychological approaches to their difficulties. However, the extent to which this is possible can be influenced by the service users 'willingness to rock the boat'. In their individual work with services users, participants emphasised that genuine attention to the relationship was foundational to therapeutic work. The trust developed within their relationships enabled the process of making sense in dialogue. Through processes of containment and shared sense-making, service users were able, to varying degrees, to slowly take ownership of the work.

Domain 1: Navigating a complex system

This domain relates to the processes used by psychologists when navigating multiple layers of context. Psychologists' work with individuals with psychosis-related diagnoses occurs within the context of teams, themselves existing within wider organisational and societal contexts. As such, the model attempts to capture the embedded nature of these relationships through nested and overlapping circles. The following categories were constructed within this domain: 'Determining a service-user's willingness to rock the boat', 'Negotiating team dynamics' and 'Adapting to organisational change'.

Determining a service-user's willingness to rock to boat

Participants described the significant role that trauma has played in the lives of the people they are working with. Many described the *'huge links between trauma and psychosis',* while others viewed '*psychosis as trauma'*. Participants recognised that some people may have developed their own ways of coping with their experiences. Reflecting on the factors that may impact someone's readiness to try psychology, participants identified the interplay between a person's history in services, openness to alternative ways of thinking and expectations of what psychology can achieve. Participants recognised that people often indicated difficulties in timing or connection by choosing not to attend.

Negotiating team dynamics

Reflecting on how experiences of the team can shape psychological work with people, participants reflected on the difficulties that come with *'trying to fit into a culture where there is an expectation that we treat distress rather than understand'*. A number of participants described how sharing a psychological perspective was dependent *'on the nature of your psychiatrist that you work with'*. When considering the conditions necessary for thinking together as a team, the ability of the consultant to *'enable others to contribute'* was an important factor in creating psychological safety. Team culture and leadership further mediated the expectations that the team had of psychology, and their receptivity to considering an alternative perspective.

While most participants spoke of how challenging it could be to be in a team where colleagues do not consider life context *'relevant or important',* participants also described how their team were '*enthusiastic', 'eager to listen and take on board'* and *'wanting to learn'* about psychologically informed, or trauma-informed approaches to working with 'psychosis'.

The ability for the psychologist to offer a psychological lens at multiple levels of the system often interacted with the expectations that teams had for psychology. Participants described a range of expectations they felt were held by the team. At times, participants felt the team held unrealistic expectations of psychology, that *'I'm going to have some magic wand'*. Others felt there were expectations to produce grand results *'we've done the medication bit. What* *are you going to do to sort out the rest?'*. Participants reflected on how clinical training has changed over time to think more systemically and to *'show leadership'*, but that team expectations can be based on '*more traditional individualistic models where the psychologist kind of comes in and does individual sessions of therapy'*. Participants recognised the importance of *'helping people to understand what the role of psychology might be',* in order to realign expectations and manage clinical resources effectively.

Adapting to organisational change

Participants described how their experience in services was set against a backdrop of constant change. Participants reflected on the challenges and opportunities that came with organisational change and shifts in ideas. Some participants acknowledged that service transformations brought some opportunities (e.g., for some, reducing the need for diagnostic certainty), however, many expressed disappointment and frustration that *'sometimes decisions are based on money rather than clients' needs'*. Some participants discussed how services were moving more towards being accountable and evidence-based, '*making sure we meet NICE guidelines erm for for all of our people rather than just hoping that we do'*. With accountability, however, there has also been an inadvertent shift towards diagnostic certainty, impacting on '*who is accepted and who isn't'*. As articulated by one participant, *'particularly following austerity, everything's led by finance'*. The ability to sustain a specialist 'psychosis' ethos can feel challenging *'when times are more difficult'*. For many, these changes highlighted the fragility of the 'psychosis' specialist role and the need to find ways to hold on to this specialist knowledge.

Domain 2. Stepping into authority

This main process in this domain is ‘defining the psychologist role’. Embedded within more medically oriented teams, participants recognised that part of their role was to offer ‘*challenge’* and hold a ‘*counter position’.* Given the fragility of specialist provision, participants spoke about how they can use their *‘power and position as a psychologist to try and spread that stuff outwards and protect that more strongly’.* To some extent, these leadership tasks were formally embedded, but there was variability in opportunity to step into this authority, influenced by participants’ freedom to define their role.

Defining the Psychologist's role

Participants described their role as 'multifactorial', providing a psychological lens at different levels to support understanding of 'psychosis' complexity. Participants felt the autonomy and flexibility afforded to them by the service was important. The way services were arranged influenced the extent to which participants were able to define their role. Ability to shape and define their role was connected to the vision they had for the service. Some participants recognised the benefits of ‘*not being a psychology department and there not being rules about who we see and what we do’.* For others, the flexibility required by the team made it difficult to maintain role boundaries. One participant explained, *‘our job as psychosis psychologists is to make sense of the symbolism and make sense of what's going on for that person.* For a number of participants there was something about helping the team *‘think in a more complex way about psychosis’.* This was particularly important given the move towards services embracing trauma-informed care, while also requiring increased diagnostic certainty.

Participants’ length of experience within services varied, again impacting on how they perceived their role. Participants reflected on past difficulties *‘working with a medic who doesn't* *place any value in the work you're doing'* or in services where '*the team don't necessarily feel like psychology works or helps'.* The legacy of these prior experiences may have also shaped participants' confidence in more actively shaping the service direction.

Domain 3: Influencing change

This last domain relates to the processes used by psychologists to influence change. In recognition that these processes occur across multiple layers of context, this domain occupies the central portion of the model. The following categories were constructed within this domain: 'Using the relationship', 'Making space', 'Making sense together' and 'Service-user taking ownership of the work'.

Using the relationship

Participants reflected on the centrality of relationships in their work, both with clients and with the team. In their work with people with psychosis-related diagnoses, participants sought to 'influence change' through building the relationship. The flexibility afforded by the service was an enabling factor in developing relationships. Participants were not confined to clinic rooms, feeling that engagement was enabled through being in the community. Participants impressed the importance of flexibility in service length, acknowledging that given the nature of people's experiences, it can '*take two years to get someone engaged'.* For participants, being seen as part of a system that has 'power-over' can impact on developing a trusting relationship. Participants reflected on a further organisational and systemic difficulty that comes with a limited psychological provision: lack of choice.

Participants discussed the importance of working together with the team. Participants spoke about the value of providing 'informal' or 'indirect' work with the staff team, seeing their role as '*supporting staff in their well-being so that they're able to support service-users'.* Where relationships had been established, participants felt they would *'be more likely to be having a bit more of an influence on what other people are doing'.* Many participants described their role as helping support the relationship between the team and service-users. This was done through mechanisms such as modelling or building in spaces for the team to think together.

Making space

Making space' captures a key mechanism for shaping a psychological approach with the team. Within significant service pressures, participants felt that part of their role was '*to maintain space for thinking, to slow people down, to help people understand, understand and formulate difficulties more holistically'.* Participants achieved this through offering team formulation sessions, reflective practice, consultation, regular training, quality circles and clinical supervision. Participants' perceived authority within their role impacted their ability to make space and was mediated by their relationships with the team.

Making sense together

At the heart of the model is 'making sense together'. This process occurs between participants and the team, between participants and service-users and the team and service-users. Success of this process is considered important to enabling beneficial outcomes with people with psychosis-related diagnoses. Participants felt that meaningful therapeutic success was a result of being alongside and helping to make sense of their client's experiences. This process was equally important with the staff team. Participants recognised that having agreement within the team on key messages enables *'containment'.* It is through the spaces described above where the team can think together to develop an integrated understanding of a person's difficulties.

Service user taking ownership of the work

As a result of making sense together, participants described how beneficial work involved a process of the service user then taking ownership, regaining a sense of control and agency. When reflecting on the service-level factors that support meaningful work, participants emphasised that *'the beginnings, the endings… has to be managed really well'.* Despite the push to discharge, participants recognised that services could support the work by staggering discharge to allow '*a bit of time to kind of process everything and kind of things to settle*'.

Thank you for reading. If you would like to send me feedback, please email me either to send your written comments or to set up a brief online meeting to comment verbally within the three areas below: Js1269@canterbury.ac.uk

How much:

1. You can see your own experience (or not) within the model;
2. You can see anything major missing from the model;
3. Anything else that occurs to you that feels important to say.

Jessica Stock

Trainee Clinical Psychologist
Salomons Institute for Applied Psychology,
Canterbury Christ Church University

Appendix S: End of study summary for ethics panel

Dear Ethics Panel,

Re: Psychologists' negotiation of the organisational context when working with psychosis: A grounded theory

I am writing to inform you that the above study has now been completed and submitted in partial fulfilment of the requirements of Canterbury Christ Church University Doctorate in Clinical Psychology. This document is a brief summary of the research process and the study findings.

The study

This grounded theory seeks to illustrate the processes that psychologists working in services across the 'psychosis pathway' use to negotiate the organisational context when working with people with psychosis-related diagnoses. Fourteen psychologists working in services across the 'psychosis' service pathway were represented within this study. Participants were located across the UK and had a range of experience working in services with people with psychosis-related diagnoses. A constructivist grounded theory methodology was used to construct a theory anchored in the accounts of those interviewed.

The model summary

Findings were constructed into three domains: "Navigating a complex system", "Stepping into authority" and "Influencing change". A table outlining each of the categories and diagram of the model is presented below, alongside a brief summary.

Domain	Category	Category description	Sub-category
Navigating a complex system	1. Determining a service user's 'willingness to rock the boat'	Psychologists stressed the relationship between trauma and psychosis, recognising different ways people have found to cope. Reflecting on someone's readiness to try psychology, participants identified the interplay between a person's history in services, openness to alternative ways of thinking, and expectations of psychology. Psychologists recognised that people often indicated difficulties in timing or connection by choosing not to attend. .	1.1. Place on the pathway 1.2. Service user's receptivity 1.3. Service user's expectations 1.4. Voting with their feet

	2. Negotiating team dynamics	Team dynamics are the interrelated psychological forces that shape team functioning. Reflecting on how the team may shape psychological work with people, participants spoke about the role of team culture and leadership. Psychologists perceived these to mediate individual team members openness to alternative ways of thinking and expectations of psychology.	2.1. Team culture and leadership 2.2. Team expectations 2.3. Team receptivity
	3. Adapting to organisational change	Participants described how their experience in services was constantly set against a backdrop of change. Participants reflected on challenges and opportunities of organisational change and shifts in ideas. For many these changes highlighted the fragility of the 'psychosis' specialist role and the need to find ways to hold on to this specialist knowledge.	3.1. Constant reconfiguration 3.2. Shifts in ideas
Stepping into Authority	4. Defining the Psychologist's role	How participants understood their role was influenced by a number of factors. Participants described their role as 'multifactorial', providing a psychological lens at different levels to support understanding of 'psychosis' complexity. Ability to shape and define their role was connected to the vision they had for the service. Ability to shape that vision appeared mediated by their history in services. The self of the psychologist was connected to reasons for choosing this work.	4.1. Psychologists' identity and Vision. 4.2. History in services 4.3. Understanding the self
Influencing change	5. Using the relationship	Participants reflected on the centrality of relationships in their work, both with clients and with the team. Participants reflected on the importance of spending time to develop trust, which enabled the next stage, 'making sense together'.	5.1. With Service user 5.2. With team
	6. Making space	Making space' captures a key mechanism for shaping a psychological approach with the team. Participants perceived authority within their role impacted their ability to make space and was mediated by their relationships with the team.	6.1. With team
	7. Making sense together	At the heart of the model is 'making sense together'. This refers to the building of a shared and integrated narrative to support	7.1. With team

		cohesion and a consistent approach. Participants felt that meaningful therapeutic success was a result of being alongside and helping to make sense of their client's experiences. This process was equally important with the staff team.	7.2. With service-user
	8. Service user taking ownership of the work	As a result of making sense together, participants described how beneficial work involved a process of the service user then taking ownership, regaining a sense of control and agency.	8.1. Service user taking ownership

Summary

The emergent theory recognises that navigation of the organisational context is enabled through psychologists' holding an awareness of the multiple interacting forces that impact on their work at organisational, team and individual levels. Psychologists' awareness of themselves in their role and the extent to which they hold a vision for change has implications for how they directed their influence. While constrained by organisational infrastructure, participants' perceived authority to create spaces within the service was mediated by their relationship with the team. Within these spaces, participants could offer the team containment, supervision, and could model compassion (to a greater or lesser extent), thus reinvigorating (where possible) team relationships with service users. These spaces further enabled the bringing together of multiple perspectives cocreating a coherent understanding of service users' difficulties.

At the heart of the theory is 'Making sense together'. Creating opportunities for the team to make sense together better enables communication of a consistent message to service users. This then has potential positive implications for service users' expectations for, and receptivity to, psychological approaches to their difficulties. However, the extent to which this is possible can be influenced by the service users 'willingness to rock the boat'. In their individual work with services users, participants emphasised that genuine attention to the relationship was foundational to therapeutic work. The trust developed within their relationships enabled the process of making sense in dialogue. Through processes of containment and shared sense-making, service users were able, to varying degrees, to slowly take ownership of the work.

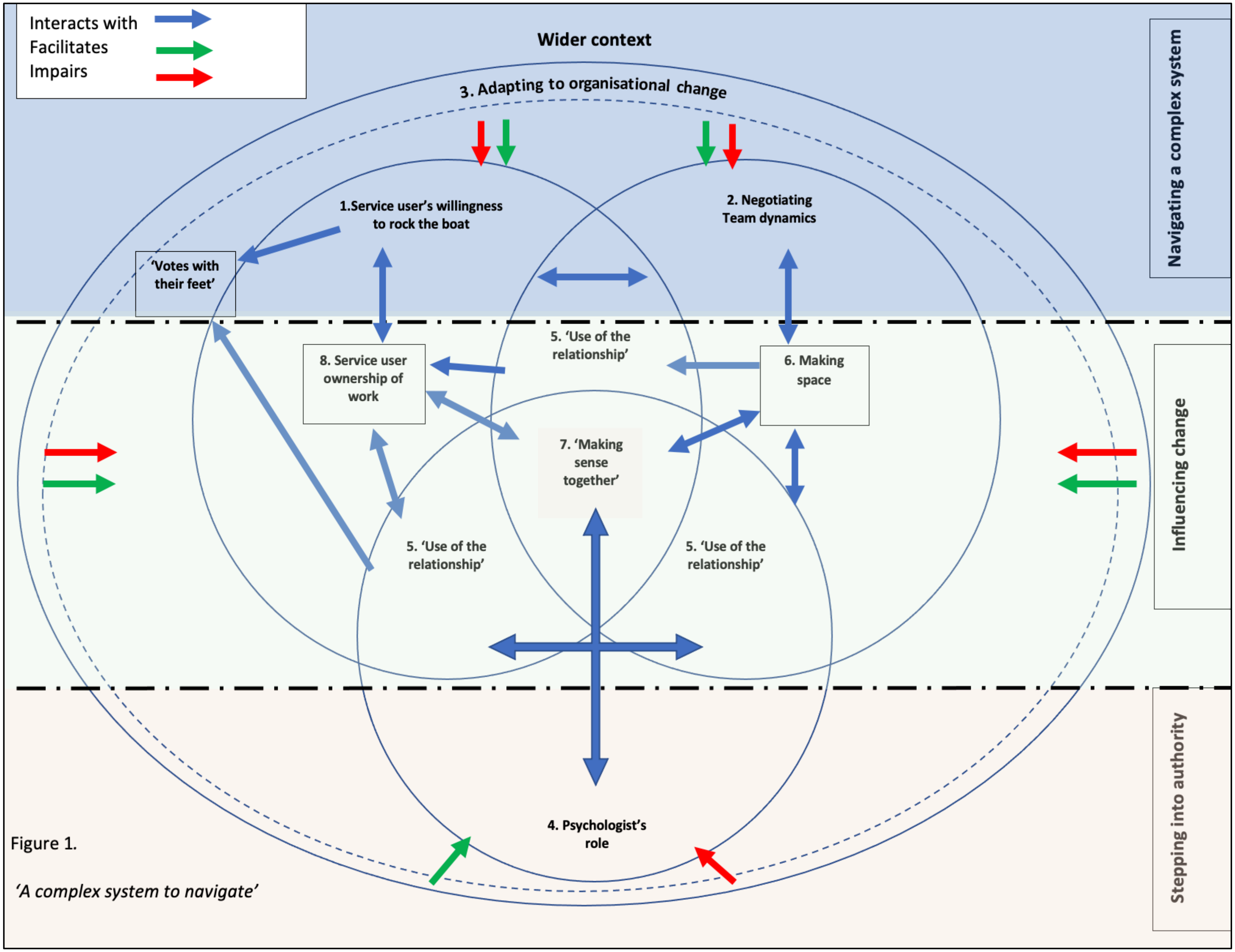

Figure 1.

'A complex system to navigate'

This study explored processes used by psychologists to promote a psychological understanding of ‘psychosis’ within a predominantly medicalised system. In navigating the organisation, participants involved in this study drew attention to the importance of therapeutic relationships, staff wellbeing, reflective practice, and creating a shared vision for meaningful care. While the findings presented are consistent with the growing literature on creating trauma-informed organisations, this study has foregrounded the importance of what I have called ‘making sense together’, that is, the collaborative development of a coherent narrative to enable both organisational containment and person-centred care. Moreover, this study hopes to offer a model with the potential to help clinical psychologists, particularly those who are newly qualified, in their thinking about the workplace context and where there may be opportunities for influence.

A summary of this research has been sent to participants and it is anticipated that the study will be submitted for publication in Psychosis: Psychological, Social and Integrative Approaches

If you have any further questions, please do not hesitate to contact me,

Yours faithfully,

Jessica Stock

Trainee Clinical Psychologist
Salomons Institute for Applied Psychology,
Canterbury Christ Church University