A Psychosocial Exploration of Resistances to Service User Involvement in United Kingdom National Health Service (NHS) Mental Health Services

Abstract

Policy promotes the active participation of those with lived experience of mental health difficulties in UK NHS mental health services, from the level of collaborative care-planning to service delivery, leadership and development. However, research indicates different forms of resistance to the implementation of such service user involvement. This article reports the findings of a qualitative, interview-based study which used Foucauldian discourse analysis and psychoanalytic theory to understand how resistances are produced through the interplay of clinical mental health professionals' subjectivity and their organisational context. Service user involvement was found to highlight conflicts within clinicians' roles. Central to this conflict was an ambivalent relationship to the power associated with these roles. Power could protect professionals from work related stresses, but could also be used to dominate, silence and coerce service users in ways that conflicted with the core function of providing care. Whilst important, raising awareness of such conflict will arouse discomfort and resistance where psychological defences are challenged. A parallel is drawn with psychotherapeutic change, in which resistance must be understood and worked with as part of meaningful change.

Introduction

Service user involvement has been a feature of UK mental health policy since the early 1990's (House of Commons, 1990; Department of Health, 2012; NHS England, 2019), and recently identified as integral to mitigating problems associated with power imbalances between services and service users (United Nations Human Rights Office of the High Commissioner, 2017; World Health Organisation 2021). But there are indications that implementation in mental health services lags behind implementation in general health (Department of Health, 2012). There are areas where it is seen to fail (Wright et al., 2015), charges of tokenistic practice have been made (Kilpatrick et al., 2017) and service users describe ongoing experiences of being marginalised (Bee et al., 2015b; Vandewalle et al., 2016).

This paper will adopt a psychosocial approach to investigate mental health professionals' experiences of service user involvement work and difficulties encountered in its implementation. There is a paucity of research exploring the subjective experience of professionals in relation to service user involvement. Professionals are often seen as a source of resistance to user involvement because they hold beliefs and values associated with forms of 'expertise' which impede the power sharing required for user involvement (Van der Ham et al., 2014; Jørgensen and Rentdorff, 2018; Bee et al., 2015a). We assert that there is a need for exploration and theorisation of professionals' position, how this is constructed by the organisational context and in turn contributes to shaping this context in relation to user involvement. As a mental health professional, the lead author has experienced being in a position to exercise power whilst simultaneously being frustrated by organisational constraints which make genuine devolution of decision-making power to service users very difficult.

Psychosocial formulations hold potential for developing a sophisticated understanding of the processes at work here through their refusal to treat the social and the psychological as separable, but instead as inextricable perspectives irreparably altered in the attempt to conceive of them as separate (Frosh, 2010). Psychosocial theories offer valuable perspectives on how individuals operate and survive within organisations (Kenny and Fotaki, 2014). A psychosocial exploration of how professionals construct and maintain an acceptable sense of self amidst the conflicting forces operating around user involvement work within NHS mental health services promises an understanding which addresses both power and psychological processes and how these, together, may produce resistance.

This study therefore sought to explore practitioners' experiences of service user involvement, paying particular attention to difficulties and tensions encountered, their impact and the attempts made to make sense of and resolve them. This focus would, it was hypothesised, generate a new understanding of resistances to service user involvement and how they are produced.

Overview of Research

Research identifies a variety of points of resistance to service user involvement in mental health. Bee et al. (2015a), in their systematic synthesis of 117 qualitative studies, found that time pressures lead organisations to adopt a task-oriented approach, prioritising efficient administration, targets and the use of specialist techniques and interventions over developing the relationships required for genuinely collaborative work. This finding is echoed elsewhere (e.g. Grundy et al., 2016; Delman et al., 2015; Jørgensen and Rentdorff, 2018; Walsh and Tickle, 2017). Bee et al. (2015b) found that top-down hierarchical service models which locate decision-making in senior staff struggled to achieve genuinely collaborative working. Van der Ham et al. (2014), Jørgensen and Rentdorff (2018) and Bee et al. (2015a) all found that practitioners' adoption of 'expert' positions, grounded in diagnostically led approaches, interfered with effective user involvement. However, Bee et al. (2015b) indicated that it is difficult to know if the beliefs, values and approaches which impede user involvement work originate within individual practitioners or are produced by the organisational context.

The subjective experience of collaborative working in complex organisational contexts is illuminated by Jansen and Hanssen (2017). They describe how collaborative care-planning on acute wards produces an experience of 'moral stress' in nurses, caught between the desire to do what they see as morally right by service users and loyalty to a system, which the authors identify as underpinned by biomedical models, which restricts their ability to practice collaborative working.

Forbat's (2006) qualitative study suggests user involvement challenges unconscious defences developed by practitioners to manage anxieties generated by mental health work. For instance, user involvement problematises binary professional/service user distinctions which enable the location of distress and mental ill health in service users. She also finds that professionals experience a threat to their sense of competence because user involvement values alternative forms of expertise and knowledge. Forbat claims meaningful user involvement challenges practitioners to reflect upon their values in a process of potentially profound change likely to evoke anxiety and which may therefore be resisted, particularly when this change disrupts defensive structures. She thus reframes resistance as a normal response to change.

Papers using social theory to examine barriers to user involvement in mental health services show how the operation of power within these services regulates the behaviour and experience of both practitioners and service users, and works against user involvement. Lewis (2009) describes how social processes within both mental health services and wider society position service users in ways that devalue their contribution by pathologising their views. She and Brosnan (2012) analyse how these processes are obscured, for example through the use of psychological constructs such as low self-confidence which locates the cause of a service user's silence in an intimidating service development meeting within the service user, rather than attending to how the meeting works to silence those unfamiliar with its procedures. In a later paper, Lewis (2014) examines how power operates via 'discursive regulation' whereby certain ways of talking and types of knowledge (described as 'scientific', 'bureaucratic', 'medical', 'quantifiable', 'emotionally controlled') are privileged within service planning meetings, and others marginalised or excluded.

Theoretical Framework

This paper attempts to integrate the psychological perspective demonstrated by Forbat (2006) with the focus on social processes which Brosnan (2012) and Lewis (2009, 2014) typify. It will do this by using Foucauldian discourse analysis and psychoanalytic theory to examine experiences of mental health professionals. Discourse analysis will be used to examine how discourses are employed by professionals to enable practices, position themselves and others and construct an identity within their work. Discourses are systems of meanings and representation that individuals use to make sense of the world (Burr, 1995; Lock and Strong, 2012). For example, mental illness can be described using biomedical discourses about embodied processes including physical processes in the brain, cognitive psychological discourses referring to thought processes, or social discourses which attend to interpersonal difficulties. Discourses have histories in which social processes, involving power and knowledge, have created and shaped them. Through these processes, some discourses come to have stronger claims to knowledge or 'truth' than others, so their use confers power (McNay 1994). For example, psychology utilises scientific discourses to make knowledge claims which can profoundly affect lives: by setting norms for 'good' mental health and wellbeing, assessing whether individuals are suitable for a given job, or fit to parent (Parker 2007).

This study will consider how discourses allow or prioritise certain actions, ways of thinking and speaking and prohibit, devalue or marginalise others. It will also examine how discourses shape the experiences of professionals through being used to construct roles, justify practices and position the speaker or those spoken about. Hollway and Jefferson's (2013) concept of the 'defended subject', based in Kleinian psychoanalytic theory, offers a way to develop this further. They describe how discursive resources are used to construct an acceptable sense of self through unconscious processes in which characteristics or practices felt to be bad or unacceptable are split off and, through projection, located elsewhere, often in a distinct group identified as being different or 'other'. For example, clinicians invested in viewing themselves as caring might disown oppressive aspects of their practice and locate them in powerful groups such as management or doctors.

There are emotional investments in discourses and discursive positions which construct an acceptable, defended self (Frosh 2010). Challenges to this self, and the discourses which construct it, will therefore be resisted because they threaten contact with that which is defended against. Forbat's (2006) findings ascribe to user involvement the potential to disrupt unconscious defences developed in the stressful context of mental health settings. This paper will extend this to consider the discursive context of NHS mental health services as we believe that, to capture the complexity of processes contributing to resistance to user involvement, a psychosocial approach is required.

Method

This was a qualitative, individual interview-based study. Foucauldian discourse analysis, informed by psychoanalytic theory, was used to examine how discourses were reflected and employed in the interview transcripts.

Though the interviewer asked about service user involvement without specifying the form that this took, participants spoke most frequently about peer support (peer support workers are individuals employed by services who draw on their lived experience of mental health problems in their work). Whether peer support is a form of user involvement or should be treated as distinct (as peer support can be provided by someone who has never used services) will not be discussed here. The findings presented reflect the participant's understanding of these terms.

Sampling and Recruitment

Participants were purposively sampled to include a range of roles and work settings (See Table One) in order to capture a variety of professional and organisational values and discourses. Given the close reading required by the discourse analytic method used, five participants was considered an adequate number. All participants worked in UK NHS adult mental health settings and had experience of user involvement work within the previous six months. Recruitment was carried out via email.

Participant	Gender	Profession	Work Setting	Years Post-Qualification Experience
1	Female	Occupational Therapist	Acute Care	Over fifteen
2	Female	Psychologist	Community	Over fifteen
3	Female	Nurse	Community	Over fifteen
4	Male	Social Worker	Specialist Services	Over fifteen
5	Male	Psychiatrist	Community	Over fifteen

Table One: Participant Details.

Patient and Public Involvement (PPI)

Two PPI groups were consulted. One group consisted of members of a mental health service user forum for discussing and influencing service developments, so had an interest in improving the quality of user involvement. The other was a multidisciplinary group of mental health professionals and hence corresponded to the participant group. Both were consulted during the planning and design of the

project. They were also consulted during analysis when selected extracts along with initial analysis were presented and discussion invited regarding whether early findings were relevant and meaningful.

Data Collection and Analysis

Each participant was interviewed twice. Interviews were held at each participant's place of work, with written consent obtained prior to the first interview. First interviews lasted between forty-five minutes and one hour and twenty minutes, second interviews from twenty-five to forty-five minutes. The gap between first and second interviews varied from three to five months.

The first interviews were semi-structured and influenced by Hollway and Jefferson's (2013) free associative narrative interview approach. An interview schedule was developed in consultation with PPI groups, though this was used minimally if participants were on-topic, the lead author relying instead on his skills as a counselling psychologist to elicit accounts of participants' experiences. These first interviews focused on experiences of user involvement work, what participants valued about user involvement, difficulties they had encountered and the sense they made of these difficulties.

The first interviews were audio recorded and transcribed verbatim. Influenced by Hollway (2009), the lead author transcribed the interviews to stay as close as possible to the full experience of the original interviews, including non-verbal aspects such as tone and rhythm of speech and his affective responses to the participants. Transcripts were analysed using Willig's (2008) guidelines for Foucauldian discourse analysis as follows:

1. Identify references to specific discursive objects (e.g. clinical care, resistance) in the text.
2. Consider the different ways in which discourses (e.g. biomedical, psychological) are drawn upon to construct these objects.
3. Consider what the participants achieve by constructing the objects in this way
4. Consider the subject positions offered by the discourses.
5. Consider the practices permitted and prohibited by these subject positions.
6. Consider what kind of subjectivity is made available within these subject positions.

These guidelines were used flexibly because, as Cheek (2004) indicates, rigid adherence risks a loss of sensitivity to what the data presents. Particular attention was paid to the final three stages, which address how the positions available to individuals within social systems make certain practices available whilst prohibiting others, and how this is experienced subjectively. We also made use of Davies and Harré's (2001) more detailed description of the concept of positioning. They describe subject positions as locations within discourses which bring a structure of norms, rights and practices. Speakers can construct narratives which assign subject positions to others, and they can also position themselves. Hollway and Jefferson's (2013) concept of the defended subject was used to interpret how subjects made use of discursive resources and this process of positioning to manage feelings and defend against anxiety.

The lead author made reflexive notes, influenced by Berger's (2015) three-part log approach, immediately after interviews and during the analysis. These notes focussed on the points of most emotional impact, the responses evoked in him and his understanding of these responses. Discussions with his co-author and clinical advisors were used to develop these understandings and check that the initial analysis had emotional resonance for others. Account was taken of the lead author being an NHS mental health professional (Counselling Psychologist) with experience of service user involvement.

Careful use of the researcher's subjectivity is central to psychoanalytic methodologies (Frosh and Saville-Young, 2017; Hollway, 1989), and here guided the selection of extracts for closer analysis.

The validity of the analysis of selected extracts was further checked in the second interviews. Extracts and analyses were presented to participants who were asked to respond, challenge or clarify the interpretations and given space to add further information. The second interviews were recorded and notes made which informed subsequent analysis.

Ethical Approvals

Ethical approval was obtained from the University Research Ethics Committee and through the Integrated Research Application System (IRAS Id: 237366).

Analysis

This paper presents findings from a broader study which looked at several different subject positions, some of which are described elsewhere (Moore and Zeeman, 2021). The focus for this paper is specific insofar as presenting a psychosocial analysis of the clinician subject position as a point at which it is hypothesised tensions contributing to resistance to user involvement occur.

Findings are presented in sections in which extracts are used to illustrate key themes: patterns of meaning which recurred in the interviews, which were associated with affect and which contributed to an understanding of resistance. Extracts were selected as described in the method, and these extracts and draft analyses were presented to the participants and the PPI groups to further check that the interpretations produced were meaningful and useful to relevant groups.

Section one introduces the split nature of the clinician subject position and how this relates to power. Section two illustrates how user involvement highlights the effects of power, associated with certain discourses, on the clinician subject position; in particular how these discourses restrict the practices available to clinicians. Section three shows that while they restrict practice, these discourses also offer emotional containment and hence clinicians may be attached to them. Section four illustrates the ambivalent nature of this attachment, reflecting the split nature of the clinician subject position, and how this split and ambivalence are also highlighted by user involvement.

SECTION 1: The 'dual edge' nature of the clinical subject position.

The operation of power was evident throughout the interviews. Participants described being subject to decisions made by others in power and the uneasy experience of enacting power to which their role, through drawing on prevalent discourses such as biomedicine (Zeeman, Aranda and Grant, 2014) and risk (Tickle, Brown and Hayward, 2014), gave them access. This uneasiness may have resulted from the study being focused on user involvement, a movement with roots in critical stances towards psy-power (Spandler et al., 2015; Weinstein, 2010), though exercising power did seem difficult to integrate with the valued function of 'caring'. Whilst describing the practices available for managing difficult situations in his clinical role, participant four illustrates this tension at the heart of the clinician subject position:

> 'for me, it's th- .. it's that dual edge … thing .. about what we do … about
> wanting to understand people and support people .. and at the same

> *time sometimes having to do things .. that .. you wouldn't want happen*
> *.. to yourself.'*
> (Extract 1. P4, Social Worker. 505-7).

This tension was present throughout his interview. For instance, he described struggles early in his career:

> '*many of the roles that Social Workers were asked to do .. felt,*
> *authoritarian … felt like, quite restrictive … felt like they were enforcing*
> *things on people rather than .. it bein' a partnership … and I really*
> *struggled with that.'*
> (Extract 2. P4, Social Worker. 54-7).

Participant two, a psychologist, indicates similar tensions. When asked specifically about difficulties relating to service user work, she describes discomfort she felt when instructing a peer support worker she was supervising to impose a limit on the number of sessions they offered a community mental health team service user:

> '*well it's difficult for clinicians at times as well isn't it .. it's difficult for all*
> *of us, we all .. we're all caregivers we're all here to be caregivers.'*
> (Extract 3. P2, Psychologist. 509-10).

'Caregiving' is presented as a core function of the clinician subject position. The exercise of power, underpinned by discourses such as economics ('resource limitations dictate a maximum of six sessions per client') or risk ('we must detain/restrict the service user for their own safety'), can conflict with this. Caregiving is fundamental; it is what '*we're all here to be*'. Given this centrality of caring, preventing this function or having to enact practices which conflict with it may represent an existential threat for clinicians. It was the exercising of power over service users which most often conflicted with caregiving and produced discomfort.

SECTION 2: Power restricts practice.

Whilst this conflict seemed an inherent feature of the clinician subject position, exposure to service user involvement or peer support workers appeared to highlight it, increasing awareness of restraints on the practice of 'care'.

Asked about the value of user involvement, participant one talks about a peer support worker using their experience of being discharged from psychiatric hospital to support a service user during a similar discharge process. The peer's input contrasts with the focus of other professionals on forms of 'care' centred on managing risk through adherence to discharge protocols.

> '*I remember once a .. Peer saying, um, "And I was really worried who*
> *was gonna get the milk .. to put in my fridge… um because, I didn't feel*
> *up to going out .. on the first day I was discharged home … but I didn't*
> *like to say to anybody about 'cos I thought they'd think I was silly." and*
> *we were all .. you know as a professional it was kind of the last thing*
> *we'd necessarily've thought about [ ] but sometimes you're so .. busy*

> *about, 'Have they got the care plan? Have they got their discharge*
> *plan?'*
> (Extract 4. P1, Occupational Therapist. 978-81)

We have elsewhere explored the metaphor of milk as a way of describing the particular quality of care provided by peer support workers (Moore and Zeeman, 2021). Milk represents a relational form of care, expressed empathically and grounded in subjective lived experience. What is significant here is how this illuminates what other mental health professionals do not, or cannot, do. The contrast with the peer worker's focus on 'milk' delineates the restrictions on their practice. Participant one attributes the clinician's failure to offer 'milk' to their role, which prioritises specialised planning processes and marginalises the type of care represented by milk. The increased importance attached to specialised planning processes is apparent in the peer worker's worry that raising the issue of 'milk' during their own discharge would have been perceived as 'silly', and because of this they kept quiet.

Text just prior to this extract further clarifies how the clinician's positioning within discursive networks limits their practice. Participant one says of service users that '*they know we've got this other agenda of bed management going on as well*' (P1.971-2). This '*other agenda*', underpinned by economic discourses which stress scarcity of resources, conflicts with the caregiving function and limits the extent to which clinicians can be perceived as genuinely empathic and understanding by service users. The peer worker, however, can voice the symbolically important concern about milk in a way that can be heard. The clinician is caught up in discursive 'lines of force' (Frosh 2003) which not only lead them to prioritise expertise-based, technical forms of care but which make attempts at empathic care appear ingenuine. Power structures the interaction, both producing the clinician's specialised, 'expert' role and limiting the practices available to it.

SECTION 3: Discourses provide emotional containment.

Discourses also serve an emotional function; they can contain anxiety. This was expressed by participant three when talking about the different ways that practitioners in different roles deal with stress:

> '*when people feel anxious about what's going on nurses might say*
> *"Have you been taking your medication" or, you know .. all of those little*
> *bits that just pull people back to more of a ... a medical model*'
> (Extract 5. P3, Nurse. 372-4).

This extract expresses this process succinctly: increased anxiety motivates a return to familiar models and practices. And it is significant that the model cited is medical, as biomedical discourses carry such weight through their affiliation with influential forms of knowledge (Zeeman, Aranda and Grant, 2013) that they can be successfully used to justify coercive practices of detention or physically invasive interventions. The same process of drawing on discourses to manage emotion occurred in most participants' accounts of user involvement. In extract four, the clinician's focus on care plans and discharge plans to the exclusion of other forms of care may be similarly motivated. These plans draw on discourses of safety and risk management, providing guidance and procedures, also backed by influential forms of evidence, which can support clinicians negotiating a transition in which the service user is understood to be vulnerable and hence risk and anxiety high (National Institute for Health and Care Excellence, 2016). The process is visible again in extract seven, where participant four comes out of a more traditional clinical role to do user involvement work but feels pulled back into the clinical role and the power it confers through access to biomedical discourses when problems are encountered.

SECTION 4: Ambivalent attachments.

But clinicians' attachment to such discourses is ambivalent. Although they provide emotional containment in stressful situations, extract seven shows how association with dominant discourses can produce uncomfortable feelings when user involvement highlights negative effects of this dominance. In the extract, participant three describes a team meeting in which the presence of a peer support worker amplified her own emotional response to a comment made by a psychiatrist:

> *'the peer worker was in the room and one of the doctors said something like .."Well I haven't got time to ask about people's carers" … and I was just really conscious that she was in the room .. and, I mean i-i-it was a bad thing to say anyway d'you know what I mean, but it wa- it just seemed much much worse, it really just shone the light on the …."Really!?'"*
> (Extract 6. P3, Nurse. 415-9).

Participant three already felt critical of the doctor's comment, but the peer worker's presence increased her feelings so that she physically cringed when describing this. Integrating the discourses represented by the doctor and the peer worker (i.e., biomedical discourses which locate mental health problems and treatment within an individual's body, versus social discourses which locate them in relationships and social networks) is complex. Time constraints force prioritisation of one discourse over another, and the biomedical wins. This is a sign of its relative dominance in this context: the psychiatrist's choice to align with it may in part be due to knowing that it offers an invulnerable justification for clinical decisions, the same reason that the clinicians in extract four prioritise planning processes.

However, for participant three the peer worker's presence amplifies the discourses which are excluded and gives them an emotional gravity. She clearly values what the peer worker represents, but her position is uncomfortable because she is, by virtue of her role, allied to the doctor and her clinical identity draws on the same discourses which here dominate and exclude. In this instance the lack of time pressurises the doctor to favour familiar, dominant discourses. Whilst time is almost always pressured in the NHS, pressure often also comes from being in distressing situations. In such situations individuals will tend to default to familiar ways of thinking and acting and familiar dominant discourses, often automatically.

Uncomfortable feelings are again evident in extract seven. Here, participant four describes his response when a service user, participating in a service development meeting comprising both professionals and service users, started behaving in a way that was interpreted as indicative of deteriorating mental health.

> *'I suppose I tha- I don't know if that's a good thing or a bad thing that we're able to do that .. but it, it kind of … changed the emphasis of-f .. the relationship .. you weren't there, he wasn't .. we, I then became a clinician, rather than a-, someone in partnership'*
> (Extract 7. P4, Social Worker. 293-6).

The service user comes to be perceived as mentally unwell, precipitating a shift from a 'partnership' relationship to a clinician/service user relationship. There was a sense of discomfort evident as

participant four spoke about the move from a collegial, 'partnership' position to becoming 'a clinician', a subject position drawing on expert discourses, such as the biomedical, which confer power. As extract two shows, participant four particularly values partnership working so the change here, towards something he had previously characterised as authoritarian (see extracts one and two), would understandably produce discomfort.

Extract six and seven capture themes present at multiple points in the interviews. Participants described or showed discomfort linked to aspects of the clinician subject position, and the presence of service users in a collegial role due to service user involvement increased this discomfort in different ways. Sometimes this was through highlighting clinicians' power and how it can coerce, silence and marginalise. At other times it brought into focus complex tensions around how power restricts clinicians' practice and their ambivalent relationship to discourses which confer power and authority. Clinical identities are constructed from these discourses so cannot exist apart from them. It could, consequently, become difficult for participants to construct a comfortable position; a coherent 'defended subject' (Hollway and Jefferson, 2013) which integrates these discourses.

Discussion

This study develops Forbat's (2006) thesis that resistance to service user involvement is usefully viewed as a psychological response to significant change. Service user involvement is shown to attenuate already complex and ambivalent attachments to discourses which empower clinical subject positions. Clinicians' emotional responses are correspondingly complex and ambivalent: change is in part welcomed (the nurse in extract seven aligns with the critique represented by the peer worker), but these discourses provide guidance and contain anxiety (see section three) and so, even where user involvement is ostensibly embraced, the resulting attenuation of discursive attachments threatens to release anxieties which have been contained and defended against. Such a process may underlie Jansen and Hanssen's (2017) description of 'moral stress' in nurses conflicted between working collaboratively with service users and loyalty to models which hinder collaboration.

The analysis also shows that the ambivalent nature of discursive attachments relates closely to power, and how it shapes clinicians' identities and practices. In her introduction to 'The Psychic Life of Power' (1997) Butler, drawing on Foucault, describes how power produces subjectivity whilst also restricting the experiences and practices available from the subject positions it produces. We can resist and resent being subject to power, yet also seek this subjection. We align ourselves with categories to create an identity, but this simultaneously limits how we act and think. Becoming a 'Psychologist' or a 'Nurse' provides a social identity which both guides and limits our actions, our thinking, the expectations of others regarding how we act and think and, through this, our social interactions. If we transgress these expectations or norms we risk being cast out of the category, resulting in significant and painful loss; a 'social death' or 'professional suicide'. We must accept subjection to societal flows of power to exist socially. Butler says our 'passionate attachment' to subjecting power derives from the fact that our ontological security depends upon this attachment. Hence in extract three, the 'caregiver' role, which prohibits certain actions, is made fundamental to the identity of clinicians.

In this study, the clinician subject position was formed through attachment to discourses which confer power and restrict practice. The biomedical model is one such discourse, evident in extracts five and six (and arguably others). Its power to form identities is clear: doctor and nurse outfits can be bought for children to embody and play out these roles. Careers in medicine are considered vocations, and an

emotionally demanding medical training will engender strong attachments to medical discourses. This attachment will deepen as discourses provide emotional containment through the stressful experiences (encounters with distress, aggression, death) of training and the subsequent career, providing guidance and encouragement in the form of positive rationales for the difficult emotional work medical professionals do.

Mental health work is intrinsically stressful, involving close contact with people in deep distress. Mental health clinicians draw on a range of discourses (e.g., psychological (Johnstone and Dallos, 2013), medical (American Psychiatric Association, 2013), social (Goffman, 1961; Beresford, 2002)) to contain these stresses by constructing an acceptable narrative for their work. As extract five indicates, anxiety may 'pull [the clinician] back' towards a familiar model which both guides and restricts practice. The phrase 'pull back' suggests an external force which brings the clinician back to safety. Faced with profoundly distressed individuals, clinicians may understandably seek subjection to familiar, authoritative discourses rather than be an agentic subject making potentially life or death decisions for which they could be held responsible.

Yet because of their power, these discourses must be subject to critique. Challenges to the dominance of biomedical models of mental health are well established (Davies, 2014; Szasz, 1974; Watson, 2019). Power and powerlessness are commonly implicated in the origins and maintenance of mental health problems (Johnstone and Boyle, 2018) and services can and do recreate traumatising power imbalances: from failing to listen to service users, to coercion and, sometimes, abuse (United Nations Human Rights Office of the High Commissioner, 2017; World Health Organisation, 2021)**.**

Butler (1997) also indicates that challenging power structures from within is problematic. Our acts and thoughts are shaped by the power structures in which they are formed. For professionals 'raised' or 'domesticated' within the discursive structures shaping NHS services it will be difficult to think and act in ways which challenge these structures. The analysis shows how the positioning of subjects as mental health professionals restricts the practices available to them (Willig, 2008). Extract four shows how a clinician's ability to move towards a more empathic stance is limited by the power that structures their role. Service user involvement brings in subjects more able to think and act outside dominant discourses and hence, as Gillard (2019) suggests, catalyse culture change. Extract six indicates how the presence of a peer support worker amplifies the importance of the social model of mental health sidelined by a time-pressured psychiatrist. In extract four the peer worker raises the issue of 'milk' in a way that clinicians could not and thus mitigates a form of organisational neglect; the marginalisation of intersubjective, empathy-based care.

There is a further difficulty to overcome. Given the passionate nature of clinicians' attachment to discourses such as biomedicine, critique must carry emotional force whilst not being received as an external attack, to be resisted with the power that these discourses provide to dismiss, silence or pathologise (Lewis, 2014; Faulkner, 2017). Finding a balance is difficult, but this study suggests that good quality service user involvement can help as, beyond merely intellectual critique, it introduces 'undomesticated' subjects with whom clinicians form collegial relationships with the potential to catalyse emotional change through experiential processes which go beyond rational arguments. Such change will produce ambivalence and tension as it challenges passionate discursive attachments, particularly where attachments are already complex and ambivalent. This is the kind of meaningful change which, as Forbat (2006) identified and therapists will corroborate (Messer, 2002; Rowan, 1998)**,** produces resistance and must be understood and worked with rather than simply pushed against.

Lapping (2007) examines the application of the psychoanalytic concept of resistance to contexts outside the clinical relationship. She describes resistance as motivated by the avoidance of difficult material or, drawing on Lacan, the attempt to maintain a coherent subjectivity in the face of change. Both are relevant here. The analysis provides examples of the emergence of difficult material for clinicians: extract four shows how user involvement highlights where power associated with clinical roles marginalises other perspectives, extract six illustrates the discomfort this can arouse, and section one shows participants' unease at exercising the power conferred by their role. The analysis also indicates struggles to maintain coherence within the clinician subject position. The points of most emotion occurred around shifts in clinicians' sense of their own identity (see extract seven). These shifts raised awareness of inconsistencies in how these identities are constructed, a core inconsistency being between the potential to coerce and the desire to care. Faced with the complexities highlighted by user involvement, the 'defended subject' (Hollway and Jefferson, 2013), so necessary in the stressful environment of mental health services, threatens to fragment. As Lapping (2007) clearly sets out, such raised awareness and fragmentation will be resisted, even when part of positive, desired change.

It is important to note that cultural and historical factors produce particular resistances to user involvement in the field of mental health. Foucault (2009) theorised that the ascendancy of reason during the Enlightenment was enabled through locating 'unreason' in those identified as 'mad', and their expulsion from society. Nowadays the broader term 'mental illness' has largely replaced 'madness' and thinking is less dichotomous, allowing those so labelled to be more integrated into society. However, a legacy of what Foucault described remains. Stigma persists (Mental Health Foundation 2021), discourses of risk underpin presumed connections between mental illness and harm to self or others (Bowen, 2016; Ramon, 2008), and mental illness remains associated with notions of 'faulty' thinking and a lack of accountability (Pilgrim and McCranie, 2013). Meaningful user involvement works against stigma, prejudice and the depersonalisation which functions to keep those designated 'mentally ill' distinct from the 'mentally well'. It does this through building relationships within which empathy breaks down such simplistic binary divisions. But if processes of stigmatising and distancing are, as Foucault suggested, part of what maintains the sense of an ordered, rational society for those on the comfortable side of the divide, the anxieties aroused by anything that interrogates these processes will be profound. If not understood and carefully handled, these feelings will produce powerful resistance.

Conclusion and Recommendations

Service user involvement brings people with experience of mental health problems and mental health service use into different and new kinds of relationships with mental health clinicians. This can have profound and potentially transformative effects on clinicians, for example raising awareness of conflicts within their role and their ambivalent relationship to power. Though many clinicians may welcome such transformational change, this study reveals complex and ambivalent processes as long-held attachments to discourses are attenuated. It indicates that user involvement can disrupt clinical identities discursively constructed to defend against the profound anxieties evoked by mental health work. Whilst insight into these defensive constructions is vitally important, the anxieties defended against must be attended to if they are not to manifest as resistance to meaningful user involvement work.

Understanding resistance to service user involvement as part of the psychological process of change suggests new ways to reduce resistance and facilitate effective implementation of user involvement

initiatives. Resistance is understood as integral to meaningful change in psychotherapy, so psychotherapeutic principles may usefully be drawn upon to provide safe relational environments in which change and its implications can be explored, examined, understood and supported. This could take the form of reflective practice groups which take account of practitioners' positioning within discursive networks of power and knowledge and attend to how power both constructs and limits professional identities and practices.

Limitations and Future Directions

Properly Foucauldian discourse analysis involves genealogical analysis, tracing the socio-historical development of discourses and their relation to power through the production of forms of knowledge (Hook, 2007). This would provide an understanding of contextual flows of power within mental health services, and how and where they interact to produce resistance. This study focused on subjective experiences of professionals as a point at which such interactions occur. However, this approach, which presupposes the individual, is in tension with a fully Foucauldian approach which would view individual subjectivities as discursively produced (Hook, 2007). The lack of genealogical analysis is acknowledged as a limitation, though such analysis, given its size, would form a significant additional study.

Whilst this study illuminates some psychosocial processes producing resistance to user involvement, the content produced in these interviews is particular to the individuals interviewed and their social and organisational contexts. Other practitioners, from other contexts, would produce further insights. The interviewer's interests and identity as a mental health professional with experience of user involvement work will have influenced the production of content. For example it may have made it harder for participants to voice attitudes and values which conflict with user involvement. Future studies would benefit from more explicit reflexive attention to such co-constructive processes. Different interviewers, occupying different positions in relation to user involvement work, could be used. A longer engagement with participants over a series of interviews or groups would provide an opportunity for greater trust to develop, enabling an examination of more sensitive material which may lie behind resistances, such as the potential to use power to coerce or exploit, unexamined prejudice or unconscious bias. Again, if such difficult-to-own material is not allowed a space to be heard and understood, it is likely to find expression in forms of resistance to user involvement such as those described in the literature and summarised in the introduction to this paper.

References:

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders.* 5th edn. Arlington, VA: American Psychiatric Association.

Bee P, Price O, Baker J and Lovell K (2015a) Systematic synthesis of barriers and facilitators to service user-led care planning. *The British Journal of Psychiatry* 207: 104-114.

Bee P, Brooks H, Fraser C and Lovell K (2015b) Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study. *International Journal of Nursing Studies* 52: 1834-1845.

Beresford P (2002) Thinking about 'mental health': Towards a social model. *Journal of Mental Health* 11(6): 581-584.

Berger R (2015) Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research* 15(2): 219-234.

Bowen M (2016) Stigma: Content analysis of the representation of people with personality disorder in the UK popular press, 2001-2012. *International Journal of Mental Health Nursing* 25: 598-6.

Brosnan L (2012) Power and Participation: An Examination of the Dynamics of Mental Health Service-User Involvement in Ireland. *Studies in Social Justice* 6(1): 45-66.

Burr V (1995) *An Introduction to Social Constructionism.* London: Routledge.

Butler J (1997) *The Psychic Life of Power.* Stanford: Stanford University Press.

Cheek J (2004) At the Margins? Discourse Analysis and Qualitative Research. *Qualitative Health Research* 14(8): 1140-1150.

Davies B and Harré R (2001) Positioning: The Discursive Production of Selves. In: Wetherell, M Taylor S and Yates SJ (eds) *Discourse Theory and Practice: A Reader.* London: Sage, pp.261-271.

Davies J (2014) *Cracked: Why psychiatry is doing more harm than good.* London: Icon Books.

Delman J, Clark JA, Eisen SV and Parker VA (2015) Facilitators and Barriers to the Active Participation of Clients with Serious Mental Illnesses in Medication Decision Making: the Perceptions of Young Adult Clients. *The Journal of Behavioural Health Services and Research* 42(2): 238-253.

Department of Health (2012) *Liberating the NHS: No decision about me, without me.* London: Department of Health.

Faulkner A (2017) Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research. *Disability and Society* 32(4): 500-520.

Forbat L (2006) Practitioner views on service user involvement: rhetoric and contradictions. *The Journal of Mental Health Workforce Development* 1(3): 24-31.

Foucault M (2009) *History of Madness*. London: Routledge.

Frosh S (2010) *Psychoanalysis Outside the Clinic: Interventions in Psychosocial Studies*. London: Palgrave Macmillan.

Frosh S and Saville-Young L (2017) Psychoanalytic Approaches to Qualitative Psychology. In: Willig C and Stainton-Rogers W (eds) *The SAGE Handbook of Qualitative Research in Psychology,* 2nd ed*.* London: Sage, pp.124-140**.**

Gillard S (2019) Peer support in mental health: where is the research taking us, and do we want to go there? *Journal of Mental Health* 28(4): 341-344.

Goffman E (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* New York: Doubleday Anchor.

Grundy AC, Bee P, Meade O, Callaghan P, Beatty S, Ollevant N and Lovell K (2016) Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing* 23: 12-21.

Hollway W (1989) *Subjectivity and Method in Psychology: Gender, Meaning and Science.* London: Sage.

Hollway W (2009) Applying the 'Experience-Near' Principle to Research: Psychoanalytically Informed Methods. *Journal of Social Work Practice* 28(4): 461-474.

Hollway W and Jefferson T (2013) *Doing Qualitative Research Differently: A Psychosocial Approach.* London: Sage.

Hook D (2007) *Foucault, Psychology and the Analytics of Power.* London: Palgrave Macmillan.

House of Commons (1990) *The National Health Service and Community Care Act*. London: Her Majesty's Stationery Office.

Jansen TL and Hanssen I (2017) Patient participation: causing moral stress in psychiatric nursing? *Scandinavian Journal of Caring Sciences* 31: 388-394.

Johnstone L and Boyle M (2018) *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Johnstone L and Dallos R (2013) *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems.* 2nd edn. Hove: Routledge.

Jørgensen K and Rentdorff JD (2018) Patient participation in mental health care – perspectives of healthcare professionals: an integrative review. *Scandinavian Journal of Caring Sciences* 32: 490-501.

Kenny K and Fotaki M (2014) *The Psychosocial and Organization Studies: Affect at Work.* London: Palgrave Macmillan.

Kilpatrick E, Keeney S and McCauley C (2017) Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health. *Journal of Psychiatric Mental Health Nursing* 24: 503-512.

Lapping C (2007) Interpreting 'resistance' sociologically: a reflection on the recontextualisation of psychoanalytic concepts into sociological analysis. *Sociology* 41(4): 627-644.

Lewis L (2009) Politics of recognition: What can a human rights perspective contribute to understanding users' experiences of involvement in mental health services. *Social Policy and Society* 8(2): 257-274.

Lewis L (2014) User involvement in mental health services: A case of power over discourse. *Sociological Research Online* 19(1): 1-15. DOI: 10.5153/sro.3265

Lock A and Strong T (2010) *Social Constructionism: Sources and Stirrings in Theory and Practice.* Cambridge: Cambridge University Press.

McNay L (1994) *Foucault: A Critical Introduction*. Cambridge: Polity Press.

Mental Health Foundation (2021) *Stigma and Discrimination*. Available at: https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination (Accessed 6th October 2021).

Messer SB (2002) A Psychodynamic Perspective on Resistance in Psychotherapy: Vive al Résistance. *Psychotherapy in Practice* 58(2): 157-163.

Moore T and Zeeman L (2021) More 'milk' than 'psychology or tablets': Mental health professionals' perspectives on the value of peer support workers. *Health Expectations* 24: 234-242.

National Institute for Health and Care Excellence (2016) *Transition between inpatient mental health settings and community or care home settings.* Available at: https://www.nice.org.uk/guidance/ng53 (accessed 6th October 2021).

NHS England (2019) *NHS Mental Health Implementation Plan 2019-20 – 2023-24.* [Online]. Leeds: NHS England. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf [6th October 2021].

Parker I (2007) *Revolution in Psychology: Alienation to Emancipation.* London: Pluto Press.

Pilgrim D and McCranie A (2013) *Recovery and Mental Health: a critical sociological account.* London: Palgrave Macmillan.

Ramon S (2008) Neoliberalism and its implications for mental health in the UK. *International Journal of Law and Psychiatry* 31: 116-125.

Rowan J (1998). *The Reality Game: A Guide to Humanistic Counselling and Psychotherapy,* 2nd ed. London: Routledge.

Spandler H, Anderson J and Sapey B (2015) *Madness, Distress and the Politics of Disablement.* Bristol: Policy Press.

Szasz T (1974) *Ideology and Insanity.* Harmondsworth: Penguin.

Tickle A, Brown D and Hayward M (2014) Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. *Psychology and Psychotherapy. Theory, Research and Practice* 87: 96-110.

United Nations Human Rights Office of the High Commissioner (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Geneva: United Nations Human Rights Office of the High Commissioner.

Van der Ham AJ, Shields LS, van der Horst R, Broerse JEW and van Tulder MW (2014) Facilitators and Barriers to Service User Involvement in Mental Health Guidelines: Lessons from the Netherlands. *Administration and Policy in Mental Health* 41: 712-723.

Vandewalle J, Debyser B, Beeckman D, Vandecasteele T, Van Hecke A and Verhaeghe S (2016) Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies* 60: 234-250.

Walsh F and Tickle A (2017) Listen to me, I'm talking: involvement and recovery. *Mental Health Review Journal* 22(2): 111-123.

Watson J (2019) *Drop the Disorder! Challenging the Culture of Psychiatric Diagnosis.* Ross-on-Wye: PCCS Books.

Weinstein J (2010) *Mental Health, Service User Involvement and Recovery.* London: Jessica Kingsley.

Willig C (2008) *Introducing Qualitative Research in Psychology.* 2nd edn. Maidenhead: Open University Press.

World Health Organisation (2021) *Guidance on community mental health services: Promoting person-centred and rights-based approaches.* Geneva: World Health Organisation.

Wright N, Rowley E, Chopra A, Gregoriou K and Waring J (2015) From admission to discharge in mental health services: a qualitative analysis of service user involvement. *Health Expectations* 19: 367-376.

Zeeman L, Aranda K and Grant A (2014) Queer Challenges to Evidence-Based Practice. *Nursing Inquiry* 21(2): 101-111.