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Middlesex University and Metanoia Institute

Conflict Within Psychosis Treatment in the English NHS: Investigating the Experiences of Patients and Psychiatrists

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Abstract

The vociferous psychiatric Service User Movement and critical elements within psychiatry form evidence of conflict within the field of psychosis treatment. Psychiatric treatment of psychosis within the English NHS was investigated to understand the conflict-ridden relationships between psychiatrists and patients. The hope was to form a bridge of understanding and dialogue between mainstream psychiatry, its fringes and the Service User Movement.

People diagnosed with psychosis who subsequently sought support from the Movement and Consultant Psychiatrists working within the NHS were interviewed, focussing upon their experiences of psychosis treatment. The patients were asked about their experiences of and feelings about their NHS treatment and help received from the Movement and, how and if the experiences had affected their self-understanding. The psychiatrists were asked about their motivations for choosing the speciality, experiences of working with those diagnosed with psychosis and their relationships with patients and other psychiatrists. Interviews were analysed using Framework Analysis, a qualitative method designed to probe individual as well as organisational processes and make policy recommendations.

The conflictual dynamic was found to result from a fundamental neglect of existential needs for meaning, hope and relationships in psychiatric training and NHS treatment. The patients felt harmed in treatment because their anxieties about psychic annihilation and need to understand their suffering were ignored. Such harms were found to derive from the lack of focus upon relationships in psychiatric services and training. The psychiatrists suffered low morale and vocational dissatisfaction because their training and work systems left them ill equipped to understand or bear the essential difficulties of the work. Psychoanalytic and other literature is cited to explore unconscious

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betrayals of human needs in the design of care systems. Ideas are offered to support all involved in the difficult work with psychosis, based upon interventions in psychiatry and other disciplines.

Chapter 1.

Introduction

A lot of my working life was spent as a mental health worker in community and acute psychiatry supporting people with serious and enduring mental health problems, mainly psychosis. Predictably, I observed and experienced a lot of misery in patients' lives and relationships. It seemed to me however that there was discord in relationships between staff and patients that was not inherent to psychosis but added to the burden of the illness. This impression was supported by the existence of a strident internal critique within and outside psychiatry, with the use of the word 'survivors' for service users suggesting conflict in treatment (Grobe 1995; Bracken & Thomas 2005; Double 2006). The user movements grew significantly over the past 30 years and have challenged the professional dominance or what Foucault (1971) called the 'monologue of reason about madness'.

I inquired into the experiences of psychosis treatment, by interviewing mainstream and critical psychiatrists and patients active in the service user movement (hereafter known as the Movement). Exploring these experiences amongst psychiatrists and patients helped me to understand the divisions and splits. I tried to attempt a metaphorical bridging, in the sense of helping the two sides understand and recognise each other's experience instead of remaining on their respective sides of the divide. The contribution I wished to make through the bridging was towards turning the monologue into a dialogue.

1.1 Development of project since initial interest

Initially, I expected everyone involved to be aware of the mistrust and conflict between mainstream psychiatry and patients and to wish to heal it. The UK and international Movement as well as the critical psychiatry network have been high profile and vociferous in their critique but pilot work showed the conflict was not universally acknowledged. Focussing upon the conflict seemed to position me against mainstream psychiatry, making it difficult to hold a neutral position in the eyes of some psychiatrists. Many patients were also angry about their experiences and uninterested in building bridges. Therefore, I stepped away from an explicit focus upon bridging the conflict, and instead directed my attention upon interpreting experiences of psychosis treatment.

1.2 Evidence of a need for this study

Perhaps a memory from my work would best illustrate my conviction about the value of this study and developing our understanding of treatment. I was attending a ward round for a young male patient diagnosed with paranoid schizophrenia, with whom I had been working at a London hospital for a short while. During the meeting, he asked, “What is this psychosis you keep talking about? Is it something to do with my wanting to touch people?” The consultant psychiatrist responded, telling him that that question had already been explained to him and repeating it would distract from the agenda. The answer seemed to upset the patient and although he was encouraged to stay, decided to leave the ward round. This episode encapsulated many of the crucial issues I hoped to address in this study, most importantly the creation of conflict in the process of treatment. Most of those present understood the patient’s question through a positivist lens, as his lack of insight due to an illness of chemical imbalance creating a distraction in the ward-round. From an existentialist Laingian viewpoint (1959) however, ‘treatment is the way we treat each other’ so attending to his emotions and appeal for contact should be privileged. The patient had been given up for adoption at an early age and grew up in a neglectful environment with significant social services involvement. I believed this young man struggled to be of any consequence or use to others and felt worthless. I understood his question as symbolic of his lack of agency and ability to impact or touch others and his upset resulted from our collective reinforcement of his impotence. In reproducing his personal context and dynamics, we missed an opportunity for dialogue. By ignoring depth and symbolism, we sowed seeds of dissatisfaction and conflict amongst all present, not just the patient.

Phenomenology or attention to experience is considered significant in understanding life and psychosis mainstream treatment is criticised for not paying enough attention to it (Hinshelwood 1994; Breggin 1993; Double 2006; Bracken & Thomas 2005; Romme et al. 2009; Statsny & Lehman 2007; Grobe 1995; Rogers et al. 1993). The critical psychiatry genre challenged mainstream conceptions of psychiatry through figures such as Laing (1959) and Szasz (1974). Contemporary critiques of treatment by psychiatrists, integrating personal and professional experiences (Freeth 2007; Moncrieff 2008) also exist. We have sociological critiques of general and particular issues such as psychiatrists’ ways of engaging with patients’ concerns (McCabe

et al 2002; Seale et al 2007). Luhrmann (2001) and Small (2006) have carried out anthropological studies of psychiatric culture, exploring the conflicts and discontent that exist. Single volume accounts of patients' and psychiatrists' experiences also exist (Hardcastle et. Al 2007). I am unaware of any research that investigates relationships between the two sides and attempts to reach a psychological understanding.

Theoretically, psychosis is considered fundamental to understanding human life, with sanity and madness occupying the basic polarities of human discourse (Eigen 1986). Without a phenomenological exploration of the 'fixity and fluidity of personality' (ibid.) in illness and health, we can't understand either but that fact goes unrecognised. Major psychiatrists link this inattention in the discipline to the 'death of phenomenology' and 'loss of the clinical core of schizophrenia' (Andreasen 2007; Parnas 2011). Both these writers point to the necessity of first person patient accounts and the need to use the professionals' own experiences in understanding psychosis. My personal experiences and clinical work have helped me to understand the evocatively bleak and withering 'black sun' (Laing 1959), where lack of nourishment from the symbolic mother leads to failure of growth. Several writers have identified inner deadness or the turning away from life as a inherent part of psychosis (Eigen 1994; Searles 1993). Mary Boyle's *Schizophrenia: A scientific delusion* (1992) addressed psychiatry's lack of engagement with such contexts and caused big waves in the field. This was happening at the time that 'Hearing Voices Network', a major part of the Movement, was getting established in the UK.

Psychosis affects roughly between 0.5 - 1 percent of the population (McCrone et al 2008; Warner 2005) with the total economic costs for England in 2007 standing at £4 billion (McCrone et al 2008). A large population is directly affected including the families and communities of those diagnosed, with the country and individuals carrying a heavy cost. I hope that my contribution through this study helps towards a better understanding of mental distress and treatment, leading to improvements for all involved

1.3 My focus and approach

I interviewed nine patients and 11 psychiatrists. The focus was upon people speaking openly in semi-structured interviews about their personal experience of psychosis treatment, including their inner dialogue and feelings. The data was analysed using Framework Analysis, a qualitative research methodology developed by Ritchie and Lewis (2003). Familiarisation with emergent data led to a conceptual framework and matrix of categories and a range of sub-themes. My approach in the project was social constructionist. In my analysis and discussion, I present a joint picture of how patients and the psychiatrists experienced psychiatric treatment of psychosis. My unique and parallel accounts suggest that the conflicts resulted from the same basic human needs remaining unmet on both sides.

1.4 Locating myself in the research and the field

In a lot of ways, this study connects closely to my life story and the lessons I learnt and continue to need to learn. In summary, these lessons are to do with our need for others in order to have a worthwhile life and the need to learn to bear the essential pain that accompanies emotional connections.

My passion and involvement in the subject were informed by personal experiences of growing up within various disempowered and stigmatised communities in Thatcher's Britain. Considerable psychological distress and hostility amongst those surrounding me meant that I lacked experience of interpersonal existence where divisions were bridgeable. Living in the shadow of such psychological diminishment produced direct emotional parallels with the experiences of patients. This emotionally barren landscape resulted in my mind developing with a sense of eternal seclusion rather than the possibility of connecting to other minds. I was, perhaps unconsciously looking to investigate damage caused to individuals by power structures and political divisions, together with the usual problems of psychological growth. I found what I sought in this study, initially identifying with patients as victims and blamed the psychiatrists as oppressors. It was perhaps a sign of a degree of health I had attained by the time I embarked upon this study that my aim was to bridge the conversational chasm and understand the conflict.

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The chief lesson of my personal psychotherapy was to help me recognise the possibility of overcoming divisions and having honest conversations. This psychological growth was necessary in seeing the walls I had constructed to keep myself safe and to recognise further that they were an illusion, borne out of hurts. I needed this study to help me understand my problem with negative capability, that I could not let multiple viewpoints co-exist because to allow that required me to dialogue with and recognise the rights of the other. I needed to integrate my various aspects to allow my reflexivity to emerge, letting alternative accounts to surface instead of my initial prejudices continuing to dominate. The study was therapeutic in that I have built upon my personal learning and recognised the existence of similar problems in systems. I now know that unless the warring parents, the oppressed and the oppressor, the colonised and the coloniser come together inside us, we do not have the complete picture and so can't move on.

The Movement call theirs "the last great civil rights movement" (Dellar 2012), drawing comparisons between their cause and other movements. I was persuaded by their arguments and moved to address the predicaments of patients diagnosed with psychosis that I knew. Awareness of psychological factors in life meant I was incredulous about the neglect of subjectivity in the face of a large body of literature and demands from the Movement. I was open to alternative understandings of psychosis for reasons of cultural differences and familial distress outlined above. My initial strategy of blaming and shaming shifted when my pilot interview and research supervision alerted me to the impact of my subjectivity and prejudices. Through immersion in the data and my counter-transferential responses to the interviews, the terrain transformed and changed the focus away from apparent professional malevolence. Perhaps my biggest piece of learning has been witnessing the wisdom of the unconscious, in choosing a study with direct parallels to my life. Starting out with a simple understanding of the conflict, I gradually recognised that there are stories behind the story of patient oppression that was my fixation. Personal growth during the research process facilitated the required distance to interpret data and ability to locate the systems within the Western social fabric, as a fractal of general and gradual move away from ontology. My conclusions about the evocation of existential fears amongst psychiatrists and their inadequate preparation for the job have come as a surprise to me. I was reassured by the findings being in line with social constructionist and

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phenomenological literature, which in turn allowed me to have confidence in drawing implications for policy and service development.

Chapter 2.

Literature review**2.1 Surveying the conflict**

Psychiatry faces the biggest onslaught on its legitimacy and existence from within the profession, other psy- professions and the Movement since the anti-psychiatry heyday (Morgan 2015). It faces criticism and allegations about its methods, dehumanising practices, ineffective toxic treatments, an insufficient knowledge-base and corrupt links with industry (Warner 2005; Thomas 2015). Under such sustained attacks, the health of the profession could be said to be in question. Through a look at the literature on relationships within and outside, I investigate the issues and remedies in more detail.

2.1.1 Conflicts within psychiatry

In a survey of European psychiatrists, Katschnig (2010) shows evidence of anxiety about the legitimacy of the profession. Nearly nine of his every ten respondents (87.9%) regarded the negative public image of psychiatry as threatening and three quarters (74.2%) were concerned about the low status of psychiatry within medicine. A majority worried about the questionable validity of psychiatric diagnoses (83.3%), low confidence in the results of scientific research (78.1%) and therapeutic intervention (72.3%) as well as confusion about opposing ideologies and concepts within psychiatry (71.2%) (ibid.). Chung et al. (2007) reconceive schizophrenia and assert that the field is contested because delusions, hallucinations, blunted affect and psychomotor activity are understandable in many different ways. This devastating illness can be seen through impersonal neurobiological approaches or a focus upon subjective loss of barriers between self, others and the environment (ibid.). Questions of boundaries between others and ourselves are fundamental aspects of human existence in need of a thorough understanding. The strict divisions existing between neural preferentialism or methodological ecumenism are attributed to our difficulty with self-understanding (ibid.). Whilst some assert that the profession is not biological enough or too bio-psycho-social and needs to become more neurological (Craddock et al 2008; Bullmore 2009), others suggest the profession wrongly emphasises technical or biological aspects and call for a paradigm change where ethical and hermeneutic aspects are primary (Bracken et al 2012). Other prominent professionals suggest mainstream psychiatric practice to be a hoax (Double 2006; Breggin 1993; Healy 2012; Mosher 1998). A cacophony of voices seems to exist within the profession, sharing journals but no common

ground. The unfortunate result for the profession is insecurity, with practitioners unsure of the ground they stand upon: “if our diagnostic categories have not been valid...then research of any type – epidemiological, etiological, pathogenetic, therapeutic, biological, psychological or social carried out with these diagnoses as inclusion criterion, is equally invalid (Katschnig 2010, p. 22)”. It is perhaps not a surprise that questions are being asked about the death of psychiatry (Morgan 2015).

According to experienced psychiatrists, the profession faces such questions due to a loss of focus on philosophy or insufficient attention to the reality of our lives (Brendel 2006; Parnas & Bovet 1991). It is criticised for depending upon superficial symptoms with psychiatrists losing their ability to conduct deep phenomenological explorations or perceive meaning behind the core gestalts of schizophrenia (Parnas 2011; McWilliams 2014). This difficulty in recognising or understanding the illness and treatment derives from psychiatric indifference to epistemology and ontology (Bracken & Thomas 2005). Brendel (2006) reminds us of the warning from a father of modern psychiatry, Jaspers (1963; p. 769): “Many a psychiatrist has said that he did not want to burden himself with a philosophy...but the exclusion of philosophy would...be disastrous for psychiatry.”

2.1.1.1 Epistemological conflicts

Neo-Kraepelinians dominate medical and popular understanding of psychosis with such principles (Klerman 1978; p. 104):

- 1). Psychiatry is a branch of medicine.
- 2). Psychiatry should utilise modern scientific methodologies and base its practice on scientific methodologies.
- 3). Psychiatry treats people who are sick and who require treatment for mental illness.
- 4). There is a boundary between the normal and the sick.
- 5). There are discrete mental illnesses. Mental illnesses are not myths. There is not one but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialities to investigate the causes, diagnosis and treatment of these mental illnesses.

- 6). The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.
- 7). There should be explicit and intentional concern with diagnosis and classification.
- 8). Diagnostic criteria should be codified and a legitimate and valued area of research should be to validate them.
- 9). Statistical techniques should be used to improve reliability.

The neo-Kraepelinian project in developing the DSM (Diagnostic and Statistical Manual) was meant to bring scientific validity to psychiatry by imposing scientific clarity and expelling subjectivity (Luhmann 2001). Doubts developed gradually about its ability to deliver the goods and its epistemological rejection of the subject (ibid.). Frances (2010) points to a recognition within the DSM that it was a tool to categorise observable aspects of illness, not a real catalogue of 'disorders' observed to exist 'in nature'. Reification resulted in psychiatrists ignoring that caveat however, coming to believe in those constructs as real and creating epistemic blunders (Hyman 2010). In this, psychiatry is doing something the philosopher Mill observed as the strong human tendency "to believe that whatever received a name must be an entity or being, having an independent existence of its own" (quoted in Hyman 2010; p. 2). Belief in the reality of these constructs makes it difficult to debate alternatives because discussions are then perceived as a threat to the profession. The epistemological need for clear distinctions between sick and healthy diverts us from a dimensional view of humanity where people have strengths and weaknesses (McWilliams 2014). Leader (2011) cites the concept of 'private psychosis' where a significant proportion of the populace is 'mad' but not distressed enough to need help. In his alternative conception (ibid.), the job of psychiatrists would be to help people understand and manage themselves instead of asserting non-existent clear, objectives lines between the mad and the sane.

Major aetiological theories based in positivist epistemology, namely (1) a biochemical imbalance within the brain, (2) abnormality of brain structures, and (3) that schizophrenia is a genetic disorder, are all in doubt (Hyman & Nestler 1996; Read 2004; Lewine 1998; Joseph 2004; Crow 2007). Even the National Institute of Mental Health (NIMH) acknowledges the failure of the 'broken brain' or 'chemical imbalance' theories (NIMH 2011; Insel 2013; Cuthbert

2014) by embarking upon their Research Domain Criteria (RDoC); a project to renew search for understandings of psychiatric illness and devise treatments. This attempt to restart pins its hopes upon 'structural or functional brain imaging and other technological measures' (Hyman 2010; p. 166) and is roundly criticised for continuing with a mechanistic understanding rather than opening up to a wider epistemology (Cuthbert 2014; Thomas 2015; Parnas 2014). Carlsson, who posited the famed dopamine hypothesis for schizophrenia reportedly concluded there was "no good evidence for any perturbation of the dopamine function in schizophrenia" (Whitaker 2002 p. 198). Dopamine supersensitivity, an intensification of the supposed pathology in psychosis is an established consequence of chronic use of anti-psychotic drugs (Burt et al. 1977; Muller & Seeman 1977; Valenstein 1998; Samaha et al. 2007). Research evidence supports the most vociferous protagonists of toxic psychiatry (Breggin 1993; Healy 2004; Moncrieff 2008) who say that attempts to correct biochemical imbalances in the brain through antipsychotics worsen the problem. Whilst some of the people with the diagnosis may exhibit abnormalities in their brains, most particularly those unmedicated are considered to have normal brains (Lewine 1998). Major genetic researchers such as Crow (2007), Joseph (2004) and Williams et al. (1999) regard the search for consistent replicable evidence for heredity in psychosis as futile. Additionally, the evidence base for widely used drugs and their therapeutic efficacy is in question (Tyrer & Kendall 2009; Katschnig 2010; Foley & Morley 2011). Ideas of the superiority of second-generation anti-psychotics in comparison with first generation anti-psychotics were overturned in a 'real-world' trial (Gilbody et al 2002; Lieberman et al 2005; Jones et al 2006). More broadly, much of the evidence for psychiatric drugs is based on their being used as mono-therapies which is often not the norm in the real world (Katschnig 2010). Mainstream psychiatric practices of widespread psychopharmacological treatment are driven by financial, social and political factors (Warner 2005; Bracken et al 2012), which explain the paucity of the research above questioning the evidence.

The fundamental point in the field is the lack of a widely accepted theory of mind-body relationship, something that has dogged psychiatry since the beginning (Kecmanovic 2011; Katschnig 2010). Obsessive focus upon objectivity in science leads to the loss of epistemological holism because psychiatrists do not attend to the self, their own or that of the

patient, in order to understand and know (Stanghellini 2013; Andreasen 2007). Mainstream psychiatry believes only in the 'real' and looks for a fault in the brain as psychiatric problems are not supposed to exist and manifest in a concept such as the mind (Bracken & Thomas 2005). Materialist belief in the tangible neglects socialised personalities manifesting in those bodies/brains or the concept of a "person" (Dewhurst & Bruges-Watson 1996). Instead of a deep and fluid self, we have the shallow, standardised self of inadequately theorised experience in mainstream psychiatry (Gipps 2010). Jenkins & Barrett (2004) critique psychiatry for assuming the existence of a generic normal, healthy self, something that is destroyed in psychosis, with the patient assigned to the liminal category of "not quite human" with a missing 'self' (ibid). This tendency in psychiatry is attributed to epistemological naivety and adherence to materialist concepts of biomedicine, with sickness an obviously different state from health (Morgan 2015; Bracken & Thomas 2005).

Epistemological revolutions have occurred in the fields of sex, gender, sexuality and race through political and social changes led by the marginalised. It is always persons who suffer not bodies, and people come to 'know' themselves through their experiences without needing tangible proof (Sampson 1993). Practitioners similarly need to become aware through experiences of their own subjectivity to understand normality and the roots of the patients' psychosis (Sass & Parnas 2003; Stanghellini 2004; Lysaker & Lysaker 2008; Sass 1992, 2014). A prominent psychoanalytic psychiatrist in the field of psychosis asserted that its aetiological roots lie in the failure of the infant's relationships to help its growth (Searles 1993). According to him, the single most ever-present threat to the paranoid schizophrenic is of ceasing to exist in the world, deriving from inadequate experiences of existing in the mind of a (m)other. The chief role of relationships is to form an embodied self from the unintegrated welter of emotions, memories, fantasies and somatic sensations. The experiences gradually come together to form coherent mental structures, falling into complex patterns to form the core of personality and this is what lacks in schizophrenia (ibid). All these authors assert their theories are not about blaming the family or reviving the schizophrenogenic mother theory, but paying attention to the role played by others in making our 'self'.

Stanghellini (2004) presents a phenomenological interpretation of Aristotle's concept of 'common sense' to help us understand the creation of our self. He suggests that during the process of 'normal' development, different modalities combine into a unity of the five senses. Our sensory self-consciousness, an embodied act, is the direct perception of the self as the hearer or seer, developing through experiencing oneself as the subject of those perceptual experiences. This integration of sensory self-consciousness helps us become aware of others and, through a process of mutual reinforcement our self develops with the coming together of our body and mind through relationships. Embodied intersubjectivity (Merleau-Ponty 2002), is our licence towards being human and crucial to the circular and lifelong process of the development of our core self and social self (Stern 2005). In phenomenological psychopathology, psychosis is a developmental problem, a breakdown of the dialectical process between our own bare individuality, significant others and the mores and institutions of our society. Two routes to psychopathology in psychosis are identified (Stanghellini 2004): firstly, a *de-personalisation* where the body becomes a thing by the failure of embodied self-consciousness where sensations, emotions and bodily functions are misunderstood; secondly, a *de-socialisation* where the self withdraws socially so the consequent lack of attunement to others means their actions or impact upon the self is misunderstood in an autistic or dis-social way. This view of psychosis as a 'disorder of the self' has echoes in Becker's (1973) understanding. He saw the diagnosed as suffering a double misfortune, with severe early psychic and physical trauma resulting in a withdrawal from the body as well as social and cultural surroundings. Whereas those without the early trauma are able to use their immersion in social and cultural roles to protect their 'selves' against existential dilemmas, those with this extra vulnerability face reality with less protection (Schwartz 2013). The embodied self-consciousness described above is very different from the disembodied and impersonal self-consciousness of mainstream psychiatry, criticised by Parnas et al (2005) and Gipps (2010). These phenomenologists promote an intersubjective turn towards internal process and a more complex understanding of our 'being'.

2.1.1.2 Ontological conflicts

Fratraroli (2001), a psychiatrist and psychoanalyst, sees positivism dominating the ontological position within our scientific society so instead of our 'personhood' or 'selfhood', modern

psychiatry assigns a 'brainhood' to us. He asserts that the consequent loss of meaning has transformed our lives from a quest or journey towards self-understanding into a simpler task of doing our laps in life's pool without bumping into others (ibid.). Feelings and thoughts such as guilt, inspiration, anxiety and shame, which would once have been seen as conflicts of the soul and motivations towards 'becoming', turn into meaningless movements of neurotransmitters. Why neurotransmitters would move without reason remains unconsidered and Frattaroli (ibid.) highlights this ontological clash in psychiatry by using the Kurosawa film, *Red Beard*. He juxtaposes the treatment methods of Red Beard, an older traditional doctor in a busy, impoverished rural clinic with those of Yasumoto, a young doctor with the latest medical knowledge who resents not being posted somewhere glamorous and urban. An uncommunicative young slave girl Otoyō, is rescued from a brothel and brought to the clinic. Yasumoto attempts to treat her raging fever by giving medicine, which she refuses in her distrust and fear so he gives up in the face of her stubbornness. Red Beard however is patient and persists despite having the medicine repeatedly thrown at him. Upon regaining some health and spirit, Otoyō asks why she was not slapped by Red Beard, betraying her difficulty in accepting kindness. Whilst a phenomenological understanding allowed Red Beard to attend to her mental and physical being, Yasumoto was trapped in focussing only upon her physicality.

Frattaroli (ibid.) rails against the equating of the brain with the mind, the spirit and the soul in most contemporary psychiatry, psychology and philosophy. He refutes scientific materialism by distinguishing between the mind, the soul and the brain acknowledging that the biological organ is essential and required. He recognises complexity in our experiencing at four different levels of body, brain, mind and spirit, with the soul as "our experiencing self, the I, an ineffable whole that integrates experiences at the level of the body, mind, brain and spirit" (ibid. p. 6). He suggests psychiatry is scientifically incoherent and inhuman by treating the chemically imbalanced brain whilst ignoring self-experience and the need for us to integrate our 'being'. Early phenomenological psychiatrists Jaspers (1963) and Minkowski (1929), founders of modern psychiatry similarly insisted that denying the spirit, soul or the self does not take away existential anxiety but removes our tools for self-understanding. Proponents of critical psychiatry (Bracken & Thomas 2005; Double 2006) claim psychosis to be primarily a problem in

being with others, making it necessary to attend to the patients' understanding of self and others.

2.2 Ontological and epistemological conflicts between psychiatry and patients

In contrast to the mainstream psychiatric disregard of subjectivity, service users focus upon the self in understanding their psychosis. Campbell (2000) in his account of his psychiatric admissions and distress says, "My first crisis admission was not a medical event. For me it was a moral event, a moral failure....none of the important implications have been medical ones...". In her biographical account, Lampshire (2009) attributes her voices to a negative emotional reaction to discovering her adoption. Significant and distressing series of events left her feeling vulnerable, worthless and defective with the increasingly negative voices confining her to the house. Psychiatric treatment of many years consisting mainly of drug treatment had no impact upon her voices until she was encouraged to seek alternatives in the user movement. In analysing her relationships with the voices, she recognised herself to be unnecessarily submissive and subjugated. She dates her reclaiming of mental health to the encouragement received within the Movement in asserting her subjectivity through a self-analysis of her world-view.

Eleanor Longden's story of psychiatric treatment for psychosis (2009) reveals similar strands. At the age of 18 she felt lost in her first year at university and found it difficult to assert herself, this was when her tormenting demon voice came into being. She slid into psychiatric care and was given a diagnosis of schizophrenia with the resultant stigma and marginalisation leading her to abandon university. She recognises her good fortune in meeting a critical psychiatrist who helped by questioning her assumptions and their role in her becoming a victim. Involvement with the 'Hearing Voices Network' led to the new self-understanding that the private demon voiced her own self-contempt and self-loathing.

A patient turned psychologist, Williams (2012) found a similar need for difficult phenomenological explorations and rejects the 'broken brain' hypothesis. He sees psychosis as

a paradoxical and automatic growth process amongst those with greater sensitivity and vulnerability to human existential dilemmas. He believes that in searching for meaning in life, the psychotic may be drowning in the same waters the mystic swims in. His research focussed upon six case studies of recovery from psychosis, exploring disparities between mainstream and alternative accounts of psychosis. Mainstream understanding of psychosis and its treatment were dominated by the “mythical biomedical account of psychosis” without an empirical basis (ibid.). He suggests that the dominance of the pharma-psychiatric complex results in psychiatric institutions and services serving the industry, not the patients and that there is a need for a paradigm shift in psychiatric thought. The necessary paradigm shift is emphasised by his inclusion of organicity in his account where psychotic breakdowns are an attempt by the patients’ embodied self to resolve an impossible situation (ibid.). His analysis of post-recovery self-assessments in his research and other studies suggests the outcomes to be healthier reorganisations of the self. He recommends the treatment focus to be upon helping patients develop greater understanding of themselves and others and to seek meaning and better relationships.

Contemporary and older patient accounts, Saks (2007) and Greenberg (1964) have also found personal histories and selves to be intimately bound up with their psychosis. Mainstream thinking retains the focus upon correcting neuro-chemical imbalances and ignores the need to explore complexity and depth, complains Barbara Taylor (2014) in her autobiographical account of the psychiatric system. She suggests (ibid. p. xii), “Today I am no crazier than I need to be to negotiate modern life. The person I am, I became through my madness, not by recovering from it into a previously healthy state but by entering into it and traveling to its roots”. The implication being that madness was a result of a disconnection between her feelings and thoughts, where asylums and psychotherapy provided the context she needed to reconnect. To become herself, she needed to travel to the roots of her madness and incorporate that narrative. Patients seek support in searching for meaning behind the surface and complain about being prevented from this by the mainstream psychiatric focus upon behaviour. Patients draw attention to their longstanding difficulties in attuning to themselves, others and their environment, something only discoverable through phenomenological explorations of depth. This struggle for reconnection

with the core of one's self and a sense of reality and security in the world was labelled 'ontological security' by Laing (1959). Another patient calls it 'a loss of footing in the world'.

What is it that I am missing? It is something so small, but strange, it is something so important. It is impossible to live without. I find that I no longer have footing in the world.

(Blankenburg 2001: p. 307).

The discussion of phenomenology above suggests our self is about greater contact with our needs, values and a sense of security in our right to exist, something that is lost in psychosis. Davidson & Johnson (2014), a psychiatrist and a patient respectively, published a moving account of the importance of ontological security and the harm incurred when it is ignored.

"For a person...crushed by vaginal and anal rape, a person crushed at the hands of mental health professionals, a person who was crushed by racism, to have an outside person assure me that I am human, that I am always human, it whispers to me when no one is here, it hugs me when life comes along and kicks me in the ass...Has anyone ever written anything on why being told "you are a human being" is so healing? I had believed I deserved to be anally raped. I believed I was filth, dirty, a whore, I believed I deserved the awful pain of anal rape. I thought my daddy was doing what he was supposed to be doing, that I was supposed to be hurt like that. And when you tell me no, Larry, when you tell me "you are a human being," you are telling my daddy to stop it, don't do that, you tell my daddy. Don't rape her, you say to him. And me too. I say, too, yeah, don't rape her daddy. She is a human being."

The Movement considers its different approach in bringing such intangible concerns into psychiatric treatment necessary because they are disregarded by positivism. Romme & Escher (1993) first called attention to something as intangible as intention, by examining differences between those distressed by their voices and others who were not. Those seeing their voices as another example of human variability and a skill, managed to use them constructively whilst those who learnt to see them as a disability were distressed. The Movement in England found an alternative perspective through seeking meaning in psychosis rather than staying with

meaninglessness in psychosis. Romme & Morris (2013) summarise their findings from a study of 50 voice hearers, with the content of voices revealing clear relationships with early history or self-image. The therapeutic thrust of their findings is in the need to investigate meaning, as the problem lay in looking at voices purely through the illness paradigm (ibid). Similarly, McCarthy-Jones (2012) talked about the history of voice-hearing seeking 'meaning beyond misguided molecules or contorted cognitions'; seeing them variously as communications from a higher self, access to inner dialogue or emergence of special abilities.

The Movement became vociferous through organisations such as Asylum, Hearing Voices Network and Mad Pride. Individuals such as Ron Coleman (2004), Jacqui Dillon (2009), Eleanor Longden (2009), Peter Campbell (2007) and Colin King (2007) were also writing and consulting widely as part of the Movement. These are compilations and individual writings of psychiatric experiences by those diagnosed. Rogers et al. (1993) champion a post-medical, user-led service with the medical focus replaced with listening and empathic responding to clients' needs and a recognition of the centrality of their social needs. They contend recovery from mental ill-health to be functions of social experiences in accommodation, employment, respect and stigma. Services wishing to be user-centred would therefore be focussed on meeting those needs rather than changing anything in the individual (ibid.). Campbell (2007) speaks about feelings of alienation, anger and frustration in service users due to devaluation of their experiences so that patients end up feeling like victims, rather than partners in the system. Campbell (2007), Buck-Zerchin (2007), Millett (1993) and others ragefully charge psychiatry with invalidating the identity of the diagnosed, by diagnosing on the basis of conduct. Buck-Zerchin (2007) asks psychiatry to become an empirical science, based on patients' experiences and possibilities of healing and not stay with a genetically caused, meaningless incurable schizophrenia. Patients express their need for help in resolving their existential dilemmas (Lampshire 2009; Longden 2009; Campbell 2000). They protest about the disregard of their 'broken selves', with an inordinate focus upon the 'broken brain', with psychiatry relating to their nerve cells not their human 'being' (Romme et. al 2009). All those patient accounts reflect human struggle with guilt, shame, submission, frozen development and constitutional vulnerability. They emphasise the environment in the development of their self and 'being' so the constitutional and the essential elements are psychic, not just physical. Ultimately, they

demand an approach where they actively participate in their treatment and are seen as subjects with agency, rather than passive objects that medical illnesses happen to.

2.3 Psychiatric engagement with the critique

How does psychiatry respond to the critique above and the conflict from within and without? Frattaroli (2001), Parnas (2014) and Kendler & Parnas (2014) have advanced trenchant critiques of disengagement between psychiatry and subjectivity, phenomenology and modern science. Both Parnas and Frattaroli report receiving acknowledgements about the veracity of their arguments but a lack of positive engagement with the critique in psychiatric literature (private communication 2015). I see evidence of this lack in Jablensky (2010), who discusses the diagnostic concept of schizophrenia and its future without mentioning the concept of 'self', subjectivity or making reference to any relevant critiques. Another prominent psychiatrist has recently written about the lack of engagement with the substantive issues in literature and surveys of professional morale (Thomas 2015). Another prominent recent article attributes these problems to NHS reforms, inter-professional rivalries and resultant insecurity amongst psychiatrists (Oyebode & Humphreys 2011). Others appear to pay lip-service to the significance of psychological and social aspects but insist the profession should resist pressures to de-medicalise and become more medical and neurological instead (Shah & Mountain 2007; Bullmore et al 2009).

Parnas (2014) points to the literature launching the RDoC, the research project to find a new understanding for psychiatric illnesses, as an exemplar of the institutional response to the critique. The RDoC is a major project of the National Institute of Mental Health, world's largest psychiatric research body and part of the US government. Such projects can therefore be seen to reflect mainstream thinking at the leading edge of the field of mental health. He asserts that the RDoC risks developing a psychiatry without psyche, due to its reductionism and emphasis upon 'mechanistic understanding' (ibid.). Others, Kirmayer & Crafa (2014), Cuthbert (2014) and Morgan (2015) agree with him. For Cuthbert (2014), the RDoC is developing psychiatric nosologies using neuroscience and behavioral science, not descriptive phenomenology by focussing upon observable behaviour and tangible neurobiology. The concept of experience used in RDoC is solely dependent on evolutionary theory, behaviourism and core cognitive

psychology, with Kirmayer & Crafa (2014, p. 9) criticising the RDoC preference for 'experience-distant' studies. The logic of using non-experiential data leads to the biological and behavioural measures in anxiety or psychosis being treated the same and give greater regard to superficial similarities than underlying reasons (Weinberger et al. 2015). Older and new models based upon rich human subjective experience to describe psychosis remain conspicuously absent, with the focus upon understanding behaviour through basic physiological responses (Parnas 2014; Morgan 2015).

The Movement also feels rebuffed in its efforts to engage in conversations about practice. Numerous references are made to the lack of engagement with charges of non-recognition of difference or issues of inequity, injustice and power against the medical model. Costa (2012, p. 87) writes of establishment efforts "to absorb resistance accounts, sanitise them, and carry them forward in ways that are useful for themselves, without disrupting...dominant practices". Services are accused of engaging patients simply to pay lip service to the principle of patient involvement, without serious attempts to challenge or change. An article in the house journal of the American Psychiatric Association (APA), led a prominent member of the Movement to ask for "dialogue, not distortion" complaining the Association has "generally refused...repeated invitations for conversation" (Oaks 2006, p. 1212). In response to an article attempting to define the concept of recovery, another prominent member of the Movement, O'Hagan (2012) suggested the mainstream inadequately honoured lived experience or engaged with justice. For her (ibid. p. 167), recovery is "a deep critique of dominant beliefs and structures that drive societal responses to madness" with services continuing to apply to it "a reductionist form of science". It seems that both critical psychiatry and the Movement, regard mainstream psychiatry to lack the philosophical tools and/or the wish to engage with their critique.

2.4 The subjective in psychiatry

The patients and critical psychiatrists ask for greater attention to the subjective in the face of domination by scientific objectivity, through tools and technology. The methods used by psychiatry in asserting itself through medical science accord with the zeitgeist of control over nature, universe and bodies through technology. The social construction of psychosis by psychiatry as chemical imbalance is described as 're-orienting our thinking about important

social matters and affecting the development of our social institutions' (Rose 1989; p. 3). In reaction, some emphasise the necessity of clinicians' use of subjectivity in understanding their patients empathically; claiming that the withdrawal of the self in contemporary psychiatry results in losing a "something", a characteristic "whatness" which is the clinical core of psychosis (Parnas 2011; Stanghellini 2013). This clinical core is a perceivable withdrawal from reality, a gestalt of schizophrenic autism, not temporally fluctuating "surface" psychotic symptoms (Bleuler 1950). Characteristic clinical manifestations are described thus: poor ability to enter into contact with others, withdrawal and/or inaccessibility, negativistic tendencies, indifference, rigid attitudes and behaviors, private hierarchy of values and goals, inappropriate expression and behavior, idiosyncratic logic and thinking, and a propensity to delusion formation (Bleuler 1950; Ey 1975). The resulting descriptions of interrelated expressive, behavioural, subjective (cognitive, affective) and existential aspects of life are a gestalt of a radically altered mental life, not the discrete dysfunctions or symptoms used in medicine (Parnas 2011). Several authors lament this loss of ability in psychiatry to pay adequate attention to inner process and the whole human, with grave practical implications for treatment (Gabbard 2014; Parnas 2011; Stanghellini 2013). The impact on patients and clinicians of this neglect of relationships and internal experience has been observed in anthropological studies and seen to dehumanize (Luhrmann 2001 p. 247).

When medications take the place of relationships, not only do patients suffer the side effects of aggressive medication, but they lose the healing power of the relationship

According to some, the narrow biomedical stance may serve to protect psychiatrists from the painful effort of understanding disturbed minds and deprived histories (Rufer 2007; Stanghellini 2013). In order to explore meaning, it is essential to engage with patients in order to understand experiences and struggles, rather than test hypotheses in a dispassionate scientific manner (Atwood 2011; Andersch 2011). Such engagement requires the use of empathy and, some suggest that the spontaneous arousal of fear and dread is at the root of the belief in incomprehensibility of psychosis in psychiatry (Stanghellini 2004, 2013). The prevalence of positivism in psychiatric treatment may be a result of the very human need to manage difficult affect by excluding all subjectivities, in patients and psychiatrists.

This “loss of the subject” may be a wider cultural phenomenon, described as the tragic consequence of modernity as we rushed to become ‘normotic’ (Bollas 1987). In this new social pathology we relinquish our individuality in order to be seen as normal. In his revolutionary book, Sass (1992) saw parallels between modernity and psychosis as all thought became abstract with everything stripped of its context and drained of meaning. For Sass (1994; p. 12), “madness is the end-point of the trajectory that consciousness follows when it separates from the body and the passions and, the social and practical world and, turns in upon itself”. Barrett’s review (1998) of Sass’s work (1992) suggested he had turned our understanding of schizophrenia on its head by rejecting both the psychiatric model of loss of reason and the excess of primitive emotions in psychoanalysis. Instead, our attention was drawn to the heightened consciousness, hyper-reflexivity and alienation leading to detachment and disengagement from life. A static universe dominated by objects, not processes and actions was evoked in psychosis whilst downplaying the emotional, dynamic embodied aspects of the world (Sass 1992). This loss of the gestalt in psychosis curiously parallels the loss of gestalt and meaning in psychiatry commented upon above by Parnas (2011) and others. Struggles in the psychiatric treatment of schizophrenia treatment derive from its tendencies towards impersonality, rationality, abstract thought and perception rather than the synthetic-intuitive thinking essential to life (Frattaroli 2001).

In this regard, McGilchrist (2009) presents a masterly analysis of a similar inexorable move from synthesis and integration towards an analytic mode of being, within western culture. Instead of an equal prizing of the mythological, religious, emotional and social with the individual and the rational aspects of our existence, a decontextualising force throws us out of contact with our nature. He locates this force in our brain architecture, where the Left and the Right hemispheres perform critically different but complementary functions. McGilchrist (ibid.) provides neurological evidence for distinct attitudes towards the world in both hemispheres, suggesting they have distinct personalities. In broad brushstrokes, the Left hemisphere atomises and focusses upon scene stills, ripping out context whilst the Right hemisphere sees the whole film and understands both the message and the philosophy. The tendency to engage with abstracted or isolated features fits the Left hemisphere personality because it wants to

manipulate the world whereas the Right engages with its organic and flowing nature. There are parallels between ideas from Luhrmann, Frattaroli and McGilchrist for psychiatry and psychosis treatment. The biomedical and psychodynamic minds in Luhrmann (2001), analytic and synthetic approaches to distress in Frattaroli (2001) and the two hemispheric ways of 'being' tap into similar issues. All insist that since humans are subjects with the ability to be objective about their experiences, both modes of understanding are required.

2.5 Healing conflicts

A recommendation to address the mind/person and body/brain splits is made so that the conflicts within the profession and with the patients can be healed. Mosher and Burti (1994) locate the problem for the discipline in its difficulty with accepting its amalgam identity of medicine, psychology, philosophy, anthropology and sociology. Brendel (2006) points to the same lack of synthesis in his title, *Healing Psychiatry*, and suggests a way forward. Using his personal struggles and the various understandings he used to resolve them, he wants mainstream psychiatry to engage with the complexity of life as it is lived. He criticises the gradual move from pluralist concerns in psychiatry and DSM towards singular, biological and reductionist systems, asking psychiatry to value its foundations in social sciences, humanities, psychology and liberal arts as well as neuroscience (ibid.). Citing a lack of pragmatism within psychiatry with professionals sticking to purist models, Brendel (2006) exalts the complexity of human social, cultural and psychological dimensions. In his model, pragmatism is about implementing the four **p's** which include 1) focussing on **p**ractical outcomes for ordinary patients, 2) the **p**luralistic nature of phenomena, tools used and explanatory concepts 3) seeking patient **p**articipation and others with different perspectives in the necessarily interpersonal process of scientific inquiry, and 4) recognizing the **p**rovisional rather than final nature of all scientific explanation. Similarly, Bentall (2009) emphasises the need for a range of skills to understand and treat psychosis as well as promoting patient involvement in assessing success.

Some psychiatrists suggest lessons in learning to manage uncertainty and complexity, by developing the capacity for what the poet Keats called, 'negative capability' (Kendler and Parnas 2014). As Keats (1817 [1899]) put it, 'it struck me what quality went to form a Man of

achievement, especially in literature and which Shakespeare possessed so enormously - I mean Negative Capability, that is when Man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after facts and reason'. Frattaroli (2001) encourages psychiatry to stop denying the uncertainty principle and insisting upon an absolute separation between the observing subject (psychiatrist) and the observed (patient). He insists that contemporary psychiatry becomes incoherent and unscientific by ignoring the relationship and investigating only the patient's chemical imbalance. According to Bohr (1977), choice of apparatus affects what we see, confirming the old wisdom that we never really see things as they are, only the reaction to our choices. Since feelings, thoughts and subjectivity in both the psychiatrists and patients motivate them, by not taking those into account we ignore large amounts of psychiatric data. The proper task of any science, including psychiatry, is to recognise the subjective and take steps to describe it objectively using the 'common language' of empathy and humanity (Frattaroli 2001). He speaks about analytic and synthetic modes of psychiatric practice producing very different types of treatment (ibid.). The positivist analytic mode investigates a self-contained individual using the current scientific, medical models for lesions in the brain rather than the ones that exist in the self. The synthetic mode of psychiatry attempts to include the subjectivities of both patient and psychiatrist and the presenting context. The conclusion reached is that allowing the mutually exclusive but complementary analytic and synthetic views in working with the soul *and* the brain is essential for a healthy psychiatry (ibid.), something Brendel (2006) could also agree with.

Bohm's idea of rheomode (1980) connects with the cultural tendency to avoid the complexity of our existence. In *Wholeness and the implicate order*, he points to how the structure of human thought and language turns our dynamic existence into something more static, by reifying thoughts into independent objective realities. He draws attention to the fact that the structure of our language makes us ignore the dynamic nature of all reality and turns it into a 'thing', so a piece of paper becomes static instead of imperceptibly disintegrating into its constituent molecules. Following his thinking, schizophrenia can become a definite brain disease instead of an umbrella term for the various presentations of those in severe emotional distress. Bohm's most significant exploration was into the existence of hidden orders of existence, pointing to an undivided wholeness with only aspects being available to our observation. He suggests the

random arrows of misfortune in psychiatric illness vanish if the context is deepened, so that randomness can no longer be viewed as fundamental. If we remain open to such orders of existence and go deep enough, we may see links between a delusion and its occurrence within that particular familial and social context. We do not see the complex and subtle orders of existence, focussing instead upon the perceptible and ignoring the imperceptible because the contemporary scientific net uses too coarse a mesh (Bohm & Peat 1987).

The conflict in psychiatry is linked to the insistence on the old objective science, raising the need for a partnership between patients, carers, psychiatrists and other professions (Morgan 2015; De Leon 2014; Brendel 2006; Bracken & Thomas 2005). To this end, Robbins (1993) recommends the abandonment of the enlightenment ideal of a single conceptual system using natural sciences alone to explain everything. Referring to the adoption of uncertainty theory in Physics and general systems theory in Biology, he urges psychiatry to accept the complexity of nature and become more scientific, through accepting multiple frames of reference for understanding psychosis. A meta-theory of psychosis would have contributions from particle physics, biology, neuroscience, psychology, interpersonal and family dynamic theories, sociology and cultural anthropology (ibid). He uses systems theory (Von Bertalanffy 1968) to construct a hierarchical systems model for mental illness, rejecting the naive interactionism currently in vogue. In this model, progressively differentiated biological systems, complete within themselves are hierarchically organised with other higher-level systems into wholes that cannot be accounted for by summing their parts. The hierarchical systems theory deals with the organisation of a human world into discontinuous but sequentially related dynamic entities or systems (Robbins' 1993). The elements of a lower level system are essential to the emergence and continuity of a higher level one but cannot sufficiently account for it. Adopting this multiple systems perspective may yield very different answers to basic questions about psychosis, its essence and its beginning and the variables that exacerbate or ameliorate it. In his model, psychopathology does not exist concretely at any single level and no single science monopolises its comprehension or treatment (ibid.). Accordingly, neuroscientific knowledge about constitutional vulnerability could help psychologists develop new theories of the human psyche whilst psychological observations of the basic schizophrenic weakness for social affinity might help neuroscientists look for unique organisations of the central nervous system. In line

with his model of interacting systems, he asserts the existence of multiple pathways to normal human development.

Robbins (1993) is advocating greater attention to the gestalt nature of our lives in proposing his hierarchical systems model. In moving away from the narrow monistic ways of understanding life critiqued above, he recommends working towards a poly-theoretical stance and the need for a paradigm shift. Andersch (2011) also points to the reductionism in psychiatry, following the political upheavals of early 20th Century with the replacement of the symbolic with the objective. He sees human life as a gestalt of symbols from law, magic, myth, religion, science and the arts making up our meaning structures, allowing us to balance inner experience with social being. Mental illness is defined as the loss of this balance and a regression towards primitive symbolic structure. He insists psychiatry lost something crucial through severing its connection with pioneers such as Cassirer (1957) who synthesised Lewin, Goldstein and Binswanger to produce a comprehensive phenomenological theory. Gabbard (1992), who argues not against bio-psychiatry, but against "the 'either-or' polarisation of the psychodynamic and the biological" (p. 991), has valiantly attempted to blend discourses of neuroscience, psychodynamics and behaviourism:

Painful events, such as separations and losses, early in life sensitize receptor sites, leading to vulnerability to recurrent depression in adulthood...ideas and images associated with depressive states could ultimately act as conditioned stimuli capable of eliciting a major depressive episode without a concrete loss or external stressor in the environment (p. 992).

All this thinking about the ways to heal the conflicts in treatment has not remained in the realm of ideas. In small corners of the world, changes are manifesting with small and bigger projects offering safe havens for patients where psychiatry combines with family work, psychotherapy, social context with involvement from all (Statsny & Lehman 2007). One such prominent whole system approach in Northern Europe is 'Open Dialogue' (Alanen et al. 2009), where recognition of the need for openness and multiple perspectives is replacing the psychiatric monologue.

2.6 In conclusion

There are fundamental epistemological and ontological critiques to psychiatry so, if it is to survive, it needs to engage with the complexity of human life. Patients want to be related to as persons with history rather than broken brains, not simply out of courtesy but because it is a crucial aspect of their treatment. The user movement details disappointments and seeks better engagement and understanding between patients and psychiatrists. Professional and lay literature speaks about the need for the psychotic self to re-form in order to gain health, requiring empathy and relationships. Not only the subjectivity of the patients therefore but that of the psychiatrists is an essential aspect of the treatment. That finding is entirely in line with modern science where the experimental apparatus includes the subjectivity of the observer and here, mainstream psychiatry appears unscientific. The task requires a move from the modernist emphasis on abstraction towards post-modern contextualisation, from an emphasis upon symptoms towards broader notions of self, health and recovery since psychosis and its treatment mean different things to different people.

My reading in psychotherapy (Mitchell 1997; Wachtel 2008; Maroda 1999) suggests that awareness of the healing power of relationships has been slow to fruition in the very disciplines supposed to epitomise it. Challenges from the political and rights movement of the past few decades have emphasised our complexities, with psychology and psychotherapy moving away from mechanistic portrayals where internal drives and biological factors dominated (Sampson 1993; Mitchell 1997). With our being always in a state of dynamic exchange with our environment, psychiatry could be forgiven for its difficulty with our process-oriented nature. We are still learning about human nature and conflicts but finding complementarity and dialogue to be important.

2.7 Coming back to the research question

When I synthesise all the literature, I have an idea of the direction of travel towards better relationships within psychiatry and with the patients. However, as I found through my pilot interviews and private communication with Frattaroli and Parnas (2015), an explicit recognition of the problem is hard to come by within psychiatry. The difficulties experienced in talking to each other and the denial of problems mean that not only do we not know how to get there;

sometimes even the need for the journey is denied. I hope that by exploring “*Conflict within Psychosis Treatment in the English NHS: Investigating the experiences of patients and psychiatrists*”, I will understand more so the required bridges and roads can be built.

3.1 Choosing the research question and methodology

My aim was to qualitatively explore experiences of psychosis treatment in the English NHS amongst diagnosed patients and providing consultant psychiatrists. My particular interest was in understanding the conflict between mainstream psychiatry and patients with psychosis, evidenced by the active and vociferous Movement. It seemed difficult to initiate an appreciative dialogue between the Movement and mainstream psychiatry or factions within the profession. So instead of naming the conflict directly, I decided to explore treatment experiences to understand issues through associations, explanations and interpretations. I used my epistemological stance and Framework Analysis to pursue my research question and ameliorate the risk of getting drawn into the conflict. Understanding and elaborating upon the experiences of my participants would, I hope, be useful in bridging the divide.

3.1.1 Rationale for a qualitative approach

I knew I was exploring a field with a lot of conflict, sensitivity and rawness where it might be difficult to acknowledge problems and facilitate discussions. It seemed important to understand the background to the conflict and the meaning behind the passions evoked. The research question and the context rather than my personal adherence to particular philosophies or methods needed to guide my choices. I was not interested in knowing what proportions of patients or participants experienced conflict or other such data but I wanted to know their experiences and understandings. An exploration of my participants' thoughts and feelings was necessary to get at the meanings behind them, suggesting the need for qualitative data. Only through getting participants to speak about their experiences and engaging with their process and the nuances of their worlds, could I build a picture of their mental and emotional associations. We make sense of the world in our own unique ways so an understanding of the meaning given, not strict cause and effect analysis was needed. Qualitative research became essential to the research question, tying in well with its ability to build complex, holistic pictures through analysing detailed informant views (Creswell 1998). Further, it was clear from the literature review that psychosis and its treatment means very different things to people. Those using a materialist explanation of pathology based in biological dysfunction would not share

common ground with people for whom psychosis is an expression of an intimate spiritual or moral crisis. Qualitative research tools facilitate the necessary in-depth exploration and understanding of the relevant phenomena (Symon & Cassel 1998).

3.1.2 Epistemological reasons for choices

The ultimate justification of the need to engage with subjectivity and meaning is our theory of knowledge or epistemological stance. Do we understand the social world by making objective observations shorn of context or individual interiority and deducing their fit with existing theory? Or do we pay attention to the context, subjectivity and behaviour and develop theory through induction and inference of our data? Whilst objectivity may be necessary to explain the impact of one celestial body upon another, subjectivity is essential to understand the effect upon a patient of being observed by their doctor. My search would have to acknowledge the existence of several truths and subjectivities because in privileging objectivity, I fall foul of complementarity theory and constructionist critiques (Bohr 1977; Gergen 2007). Dilthey, an early proponent of qualitative approaches, is supposed to have asserted that different methodologies were required in natural and human sciences as “we explain nature but can only describe human relations, with meaning crucial to our understanding” (Ratner 2008, p. 515). Understanding conflict in psychosis treatment cannot be done without looking at subjective meanings of psychosis and treatment.

Whilst deduction used to be the only valid method of inference in positivist science, induction, abduction and deduction are crucial in modern scientific endeavour (Fox 2008). Sole use of deduction or hypothetico-deductivism fragments the social world by abstracting too much and leaving out the context. Qualitative methods help restore balance by retaining rich links with the data and context. Some insist that we have only recently begun to understand the complexities of our relational and intersubjective nature because of the development of qualitative epistemology (Gergen 2007; Sampson 1993). Others assert that the previously dominant methods of positivist objectivism and deduction led to the use of disembodied or decontextualised facts (Ratner 2008). That disembodied perspective led science into developing objective theories, now being questioned in light of the emphasis upon subjectivity

in modern science (Bohm 1980). If subjectivity is critically involved in physics and biology, it is surely worth paying attention to in emotional and physical health matters.

Intersubjectivity shapes us, with our self-coming into existence through interactions with others; it is therefore an ontological rather than a developmental achievement (Stolorow, Atwood and Orange 2001; Hobson 2004). If our personhood forms through our interactions, understanding patients and psychiatrists needs a deep engagement with physical, psychological and spiritual aspects in the other as well as the self. This necessary engagement and understanding was crucial in choosing my method, ruling out quantitative measures because of the need for a 'subjectively guided process' (Kirschenbaum & Henderson 1990, p. 268). In asking questions about experiences and interpreting the answers, my own subjectivity and those of my participants becomes essential to the study. The chosen methodology had to be in line with such ontological and epistemological needs, with only qualitative methods able to allow the requisite flexibility of inference and context.

3.2 Choosing approaches and monitoring processes

Approaches to qualitative data analysis can be divided into three categories, according to Smith & Firth (2011):

- Socio-linguistic methods that explore construction of identity through use and meaning of language such as discourse and conversation analysis
- Methods that explore social processes and use that understanding to develop theory, typified by grounded theory
- Methods that describe and interpret participants' views and experience of the world through content and thematic analysis.

My primary objective of understanding experience inevitably meant an exploration of social and individual processes within psychiatry, the Movement and the mutual conflicts. The method also needed to pay attention to experiences and their meaning for individuals, with a view to understanding the conflicts and any measures needed to bridge them. Although generating new theory was not the aim, it may be a by-product of the understanding gained. With my focus upon inner experience rather than identity, it was a relatively simple decision to discount the use

of socio-linguistic methods. The language used can indicate power dynamics in any setting and inform how one sets themselves apart or above another group. If my primary interest had been to investigate power dynamics between psychiatrists and patients, I may well have used discourse analysis.

As Firth & Smith (2011) illustrate, qualitative research methods usually divide so that a phenomenological exploration is incompatible with investigating social processes. Although I was interested in generating rich data on my participants' lived experience of psychosis treatment, I did not want to stop there. Interpretative Phenomenological Analysis or other such methods would have focussed the study exclusively upon participants' descriptions and attribution of meaning, without developing an understanding of the social processes. As well as 'a thematic description of pre-given essences and structures of lived experience' (Starks and Trinidad 2007, p.1373), I wanted to understand the social phenomena framing those experiences. My wish to investigate and understand psychosis treatment, the social conflicts and construct a bridge needed a methodology able to let theory emerge. Grounded theory may have been appropriate and allowed me to posit 'plausible relationships' among sets of concepts arising from collected data (Strauss & Corbin 1998). I would have understood their social worlds through induction or testing propositions against the mutual experiencing of my participants rather than producing 'absolute truths' (ibid.). Specific interest in an aspect of the field such as the conflict goes against the spirit of Grounded Theory, however, as do my a priori interests in bridging the conflict, my choice of patients from the Movement and wish to make policy recommendations (Starks and Trinidad 2007). I was therefore led to reject Grounded theory as a methodology and choose a qualitative mixed methodology.

3.2.1 Choosing Framework Analysis

This methodology for qualitative research was developed by social policy academics at a London university for use in applied policy work. The developers, (Ritchie & Spencer 1994) felt that applied policy research goals fall into contextual, diagnostic, evaluative and/or strategic categories. Contextual research investigates 'what exists' including experiences and needs whilst diagnostic work seeks to understand 'why particular problems or needs exist'. Evaluating the 'effectiveness of what exists' by identifying barriers could describe the third category while

developing 'policies or actions to deliver strategies and/or meeting needs' comprises the last category. My goals of understanding my participants' experience and a bridging of their conflict, fit Ritchie & Spencer's (1994) categories of contextual and strategic research.

Framework Analysis aims to be a flexible tool for qualitative analyses by generating themes without aligning itself to any epistemological or theoretical approaches (Gale et al 2013). Ritchie & Lewis (2003) suggest their method to be the right tool to address real problems in the healthcare field through its ability to explore social and individual processes together. Their 'constant comparative method' is similar to Grounded Theory through its insistence upon themes and analysis grounded in the data (Srivastava & Thomson 2009; Gale et al. 2013). The ability to manage the data generated and show an empirical basis for its conclusions is the ultimate test for all qualitative methodology. Ritchie & Lewis (2003) argued for the epistemological legitimacy of their method through the use of data matrices and audit trails. Stages of qualitative analysis in their method gradually move us from the cacophony of raw, rich data through a sense-making process of abstracting the experiential essence and forming a narrative. Framework Analysis facilitated the carrying out of a thematic analysis of transcripts by comparing and contrasting experience across my two groups of participants. I was also able to retain context and connections between individual accounts and the meaning attached to individual experience. Ultimately, the analysis of data and emergent themes led through induction, deduction and abduction towards a coherent theory of process in psychiatric treatment.

The needs for reflexivity and awareness of social complexity are accommodated in Framework Analysis, with necessary steps taken at all stages from research design to analysis (Gale et al 2013; Smith & Firth 2011). I trusted my reflexivity skills developed through training and practice in psychotherapy, in rigorously maintaining my capacity for honesty and awareness of my motivations and emotional responses. I also found Framework Analysis to be flexible and robust to allow for this process.

3.2.2 Reflexivity and trustworthiness

In this research, I observe social and individual processes during interviews of experiences of psychosis treatment with plenty of opportunity for emotional entanglement. Having emphasised the impossibility of the separation of observer from the observed (Bohr 1977), I had to report upon my experience of the individuals, how they were impacted by the others in their stories and, by themselves whilst managing the emotions evoked in me. Experiences germane to their identities were discussed, particularly by the patients, since psychosis is described as a 'loss of self' (Searles 1959; Winnicott 1945). The phenomenological process of my 'engagement as a process of knowing' (Tufford & Newman, 2010: p. 83) was essential to the research. In this complex process, I needed to engage with and get inside others' experience whilst retaining my self-conscious criticality and distinctness. The field of phenomenology recognises the impossibility of research without presuppositions, accordingly I needed to remain aware because of the impossibility of bracketing my ideas about the psyche, self, mental health and our need for others (Heidegger 1962).

My stance in this research was constructivist, critical realist in particular, acknowledging the physical existence of objects and my perceptions of objects and events as subjective (Pilgrim and Rogers 1997). Unlike naïve medicalism, I assume that phenomena such as psychosis do not simply exist in nature, ready to be discovered and verified. Instead, we need to take a reflexive position and approach all knowledge critically and be aware of our values and our socio-political position (Pilgrim et al. 2010). When I sat with a participant to discuss their experience, I was aware that we might only superficially be speaking about the same issue. Our perception and interpretation of each other and our words would be saturated with our experiences, beliefs and values and, fundamentally affected by our individual and collective socio-political context. The psychiatrists may have expected me to share their beliefs because of the dominance of the medical view whilst the patients may have expected me to misunderstand or hold an opposing worldview. Our views on treatment would be saturated with our ideas of mental illness and distress. Our ideas of treatment would sit within our respective ontologies, without being explicitly talked about or even known by the speaker. In view of all that is unknown and remains thus, all quantitative and qualitative research ought to be seen as an interpretation. I, the researcher interpret the interpretations made by the participants of events

and experiences, with the narrative being another construction because another researcher might interpret the same events very differently.

I needed to adopt an attitude of reflexivity and heighten my awareness of own ideology, emotions and beliefs and those of my participants. If my analysis and interpretations had been in line with my initial worldview, my prejudices would have dominated, as I would not have left any room for surprise. For these reasons, I recognised the need for a thorough look at subjectivities (including my own) and objectivity, since what we know sometimes merges with how we come to know it (Etherington 2004). That most people 'know' psychosis to be a real and diagnosable illness can be hard to distinguish from their need to 'believe' in a strict demarcation between illness and health or an 'us' and 'them'. I was aware of my tendency to side with the patients and minority psychiatrists and create a 'them' of mainstream psychiatry so I needed to be mindful. In systemic thinking (Robbins 1993; Sullivan 1971), psychiatry is a study of interpersonal relations where psychiatric distress derives from the system one belongs to whereas mainstream psychiatry emphasises individual psychopathology. Within the mainstream, diagnosis locates illness within individuals, seeing the person as self-contained instead of as a process at the border of self and other (Jenkins & Barrett 2004). Reflexivity required me to use my awareness of the human tendency to see individuals not systems, and avoid a repeat by locating the problem within individual psychiatrists.

My initial passion and involvement in this subject connected with my political outlook and identification with the oppressed in terms of gender, diagnosis, race and sexuality. I recognised early that my need to protest informed my choice to work in mental health, with the psychiatric profession standing in for the establishment. I started out very critical of mainstream psychiatry and was determined to find evidence for ill will within the profession. This awareness highlighted the need for reflexivity because strong emotions in my participants and me might contaminate the outcomes and damaging the reliability of the research. Through this possibility of my inner life prejudicing the findings, I was moved to adopt a phenomenological and appreciative approach. Recognising and appreciating my prejudices and the validity of my anger through personal psychotherapy helped me to be more open towards psychiatry. Concern for an honest, reflexive and trustworthy account has been present since the beginning

therefore. Uneasy relationships between social constructionist methodologies and notions of validity and reliability exist because those concepts derive from positivist viewpoints and beliefs in tangible, reproducible phenomena. I was not measuring phenomena, but noumena, the deeper structures of being, which can only be constructed through participant accounts. In such situations, validity is only measurable through my interpretations making sense to others (Woods 1998). Debates within qualitative methods have reconsidered quantitative concepts of generalizability, internal validity, reliability, and objectivity in qualitative terms. Alternative terms such as credibility, dependability and confirmability have allowed qualitative workers to bring trustworthiness into their research, without capitulating to the tyranny of objectivity (Seale 1999). The comprehensive audit trail in the appendices documents my analytic procedures and forms a part of my attempt to establish trust.

That my findings include existential constants such as our need for meaning, hope and relationships emphasises their trustworthiness. The credibility of my reflexive stance was confirmed when the findings reflected the primarily systemic, rather than individual nature of the issues. I observed and reflected upon the stress of working with psychosis during interviews, allowing me to begin to appreciate the insufficiencies of mainstream psychiatric training. I was surprised to find myself affected by the emotional toll of the work upon psychiatrists and how they were left unprepared by the system. The gap between my imagined and actual findings, together with my increased concern about the wellbeing of both sets of participants helped me to trust my stance.

3.3 Sampling strategy

After thorough consideration of the ethical, logistical and practical factors affecting my need to recruit psychiatrists and patients, I decided upon the following: The patients needed to have been diagnosed with psychosis or schizophrenia for at least ten years but did not need to be currently accessing treatment. They were recruited exclusively through the Movement to ensure on-going exposure to alternative ideas and opportunities for support. I was able to find four people who met the criteria at the first attempt and gradually found another eight through a mixture of snowballing and approaching others within the Movement. I was only able to interview nine as three dropped out for a range of reasons before their interviews. The

psychiatrists needed to be working at Consultant grade in the NHS to ensure sufficient experience of working with psychosis. Accordingly, I began to approach psychiatrists through personal contacts. It proved difficult to recruit those from the mainstream of the profession, as most did not seem interested in the topic. I was only able to recruit two in this way. I therefore approached colleagues through the International Society for Psychological approaches to Schizophrenia and the Psychoses. My request was to recruit psychiatrists sufficiently interested in the issue but not too firmly wedded to alternative methods. The rationale for this stipulation was to avoid an imbalance in my sample, of having too many who were motivated enough to join a political organisation such as this. I was able to gain five more through this method and another four through snowballing with the seven I now had. I was eventually able to interview nine people diagnosed with psychosis and 11 Consultant psychiatrists, making a total of 20. One of those diagnosed felt overwhelmed during the interview and was unable to continue that day, but insisted upon taking part by sending her answers to my questions in print at a later date.

Table 1. Patients and their demographics

Patients diagnosed with psychosis	Age Range	Years since diagnosis	Currently in NHS treatment	Gender	Ethnicity
"Nicola"	30-40	11	Yes	Female	White British
"Keats"	40-50	20	No	Male	White British
"Ben"	40-50	17	Yes	Male	Black British
"Jane"	40-50	26	Yes	Female	White British
"Fay"	30-40	12	Yes	Female	White British
"Amy"	50-60	20	Yes	Female	White British
"Ann"	40-50	14	Yes	Female	White British
"Jenna"	40-50	20	Yes	Female	White British
"Bonnie"	50-60	35	No	Female	White British

Table 2. Psychiatrists and their demographics

Psychiatrist	Age range	Years as consultant	Ethnicity	Gender
"Hans"	50-60	20	White European	Male
"John"	60-70	30	White English	Male
"Don"	60-70	30	White English	Male
"Len"	50-60	20	White English	Male
"Raj"	30-40	1	Indian	Male
"Gita"	30-40	2	Indian	Female
"Dale"	40-50	10	White British	Male
"Anna"	40-50	12	White British	Female
"Keith"	40-50	13	White English	Male
"Doug"	40-50	14	White British	Male
"Seth"	40-50	15	White British	Male

3.3.1 Pilot study

Pilot interviews were an opportunity to refine study aims, the interview questions and my interview style with participants before data collection began. They were a crucial component in road-testing my research and identifying pitfalls.

I was able to carry out pilot interviews with two consultant psychiatrists and an ex-patient. The pilots made me aware of sensitivity amongst psychiatrists towards any exploration of their practice. I recognised that my familiarity with the Movement had anaesthetised me to the linguistic implications of the use of the word 'survivors' for patients, suggesting the psychiatrists were 'abusers'. My questions aroused fear and prejudice so I decided to emphasise my aim of bridging the divide between patients and psychiatrists. Something similar occurred with the patients as I looked out for the impact of my questions and found the right balance between

intrusion and respectfulness. I had to emphasise my interest in bridge-building between the two camps without giving away too much of my politics. Asking for feedback on the impact of various questions allowed me to learn more about the effect of my biases on interviewees. With both groups, I recognised more of the perils of letting my personal biases affect the tone and language I used. Through conducting, transcribing and analysing the pilot interviews myself, I was sensitised to what in-depth and meaningful data may look like.

3.4 Procedure

I met up with all of my service user participants once in local cafes so they were able to ask any questions about my aims before agreeing to take part. My aim was to introduce the patients to the research and gain informed consent, however such a location raised the risk of personal familiarity and friendship. Keeping the focus of the meeting upon the research rather than a social chat allowed me to minimise those risks. At this meeting, all the participants were given a form with my research details to gain informed consent (Appendix 1). They were requested to sign and return the form at the interview, the date and time of which were arranged at this first meeting. None of the psychiatrists went through these preliminary meetings, even though they were offered the choice, mostly due to time constraints. The informed consent forms were emailed prior to the interviews, during the process of negotiation.

3.4.1 Interviews

Interviews with six patients were held in their own homes or work places in various parts of England. The other three interviews were held at the offices of a well-known charity in Central London where I rented a small meeting room. Ten psychiatrists were interviewed in their offices or workplace across England. The final psychiatrist wanted to meet at his home. The interviews mostly lasted between an hour and ninety minutes except with one psychiatrist and one patient, being just above two hours. All interviews were recorded on a digital machine.

At the start of each interview I carefully explained my need for it not to be a 'standard' interview comprising set questions, but more of a discussion about their experiences in psychosis treatment. My purpose in doing this was to facilitate participants to speak freely so I could gather rich data about their thoughts and experiences, rather than steering the discussion. In

line with Willig's (2013) guidelines for semi-structured interviews, I had an 'agenda' of questions to keep myself 'on track' without losing myself or letting the questions become too specific and directive. As indicated in the section on pilot studies, I was aware of the risks of betraying my biases and the need to develop a collaborative approach within the interview, to model my aim of building bridges (Smith & Eatough 2007). I took a phenomenological route of open questions about experiences and following up on the responses, whilst remaining reflexive about the effect of power dynamics upon information gathering (Kvale & Brinkman 2009; Charmaz 2006). This allowed me to confirm my understanding whilst maintaining continuity and gaining a sense of their narrative. I used notes made during each interview and memos of my experience of the interviews and interim analysis to formulate future questions so that emergent themes could be followed up (Ritchie & Lewis 2003).

I started off by asking the patients to confirm their diagnoses of psychosis, the length of diagnosis and whether they were still in NHS treatment. I was aware of the possibility of privileging diagnostic tools and positivism but also needed to ensure the trustworthiness of my research. After confirming these general facts, they were encouraged to tell their story of psychosis treatment following a loose structure. The follow-up questions aimed to clarify their understanding of their needs at various stages of their patient career and their experience of how those needs were met. An account of their experiences with the Movement was followed by a comparison between their experiences of treatment inside and outside the NHS. Finally, their understanding of essential and necessary elements of good treatment was sought. With the psychiatrists, I started off by asking about their interest in psychiatry as a medical speciality and the impact of their context upon their interest. We then moved on to their current understanding of psychosis, its treatment and the impact of personal experiences and feelings on their understanding. I paid close attention to any major changes in their understanding of and feelings about the treatment of psychosis, asking follow-up questions as needed. The interview questions I used are reproduced in Appendix 2.

Together with close phenomenological and reflexive awareness during the interviews, I was careful not to invite too negative or positive a transference from either group. There was the risk that the patients might see me as a hostile professional, producing anxiety and inability to

speak openly. Alternatively they might see me as an ally, critical of psychiatry and engage in bashing the profession, at the cost of building a bridge. With the psychiatrists, I was careful in my use of language, taking account of fears of epistemological criticism of psychiatric practice or being seen as a hostile rival professional.

3.4.2 Transcribing and familiarisation

After personally carrying out verbatim transcriptions, I felt immersed in the narratives so the informal process of coding and analysis began at that point. I left wide margins to make notes to facilitate later coding or indexing as Ritchie & Lewis (2003) call it, with the notes being a way to record significant thoughts or ideas. In order to transport myself back into the experience, I listened to each interview fully before coding.

3.4.3 Coding, Indexing and Analysis

A range of views exist over how coding ought to be done, with some following strict conventions on a code or two per sentence, implying significance in each sentence. Through familiarisation, I had already noticed the existence of different styles with some speech being precise and densely populated with significance whilst others were sparse with an occasional gem. I therefore began the process of coding, scanning each line for content with each code being simply a label for words or phrases denoting some significance in participant experiences. I was searching for references to substantive things such as particular incidents, behaviours, practices or structures (organisational or mental), values or principles in treatment that seemed important to participants. I also looked for expression of strong feelings in treatment or within interview which conveyed significance, such as problems in communication or relationships. Examples of coding from patients about relationships and psychiatrists about understanding of psychosis are reproduced in Appendix 3. The hundreds of codes derived from all the transcripts were organised together with my sense of the issues raised, to develop two separate frameworks for the participants. Ritchie & Lewis (2003) advise upon the need to stay with description at this stage for purposes of sifting and sorting, rather than interpretation or explaining. Developing the Framework categories therefore is akin to drawing the tree under which all the participants' responses fall, with each main branch having several sub-branches. A

priori concerns as well as emergent data are included in the Framework. The conceptual framework for patients' responses consisted of four main indices, namely:

- **Personal and psychiatric history**
- **Experiences within statutory health networks**
- **Experiences in external networks**
- **Changes in narrative since diagnosis.**

Personal and psychiatric history, for example included significant life experiences prior to and post diagnosis and how patients understood them. *Experiences within psychiatric networks* on the other hand was a sub-index within *Experiences within statutory health networks* which described negative and positive feelings and experiences from their NHS treatment.

A separate conceptual framework for data from the psychiatrists had four main indices, namely:

- **Understanding self and psychiatry**
- **Understanding psychosis**
- **Managing problems**
- **Impact of paradigm.**

All the transcripts were labelled with tags derived from the conceptual framework and used to represent all of the data in a matrix. The sheer quantity of raw data meant that it could not be presented verbatim and was therefore summarised and charted, with each column representing a sub-branch of the Framework, with uniform representation from each respondent. I produce samples of the charted Framework in Appendix 4. A strength of this method is the analytic flexibility available to investigate data through such representation. Researchers can move back and forth between layers of abstraction and raw data, within a column and across respondents, to ensure that the increasing conceptual refinement remains valid.

Gradually, after a long period of immersion in the emergent data and various stages of categorisation and abstraction, a conceptual scaffold began to develop. This needed to be something upon which the final descriptive and explanatory accounts could hang and was achieved by using the matrix to stay in touch with the raw data and my own experience of the

interviews. I focussed upon my research question of understanding the conflict in psychosis treatment in order to find patterns and make sense of the meaning my participants tried to convey. Though it was sometimes addressed, mostly I was not explicitly told why relationships were difficult. I sought understanding and patterns by interpreting statements using my experience and psychological and philosophical knowledge. Qualitative research is a process of intersubjective meaning-making through imagination, interpretation and conceptual input, not through accessing experience directly (Parkinson et al. 2016). At first, I mined the data to try and understand the two sets of experiences separately using the two frameworks. Painstaking summaries of data along every branch of each framework were produced, for example, patients' experiences in external networks or psychiatrists' understanding of psychosis. I then expanded my writing to include quotes from participants. As the raw data was understood better, patterns became visible gradually and helped move me towards greater abstraction and bring both groups under this single conceptual scaffold, which I reproduce, in Appendix 5.

- **Understanding psychosis**
- **Understanding human ontology**
- **Working with human complexity**
- **Significance of relationships**
- **Systems design issues.**

In Appendix 6, I provide samples of relevant sub-indices and their data source as evidence of my audit trail. At an advanced stage of the analysis, it seemed that unmet needs on both sides were leading to frustration and creating the conflictual relationships. From the start, it had been clear that both patients and psychiatrists wanted and needed relationships as part of the treatment. The lack of nurturing relationships was an obvious problem that the data threw up. Other issues were more obscure, such as the repeated reference by both sides to the neglect of the inherent complexity in psychosis, coinciding with complaints about the tendency to simplify everything. Further detailed investigation of the raw data, for what got lost through simplification or neglect of complexity revealed the answer to be the existential needs for meaning and hope. This recognition enabled me to arrive at most of my core concepts. As I paid attention to the patients' use of terms such as paradigms, world-views or 'a different

language' and the psychiatrists' difficulties in 'being with patients', the contributions of systemic elements in the neglect of ontological complexity became clear. This became my fourth and last core concept. Taylor (1971: p. 5) wrote: "But how does one know that [an] interpretation is correct? Presumably because what is strange, mystifying, puzzling, contradictory is no longer so". Although a disheartening puzzle at various points, I could suddenly see a clear shape to the messages being delivered by my respondents.

I produce examples to demonstrate the process of refinement in arriving at the core concepts 'Patients' need for relationships' and 'Psychiatrists' need for hope' in Appendix 7.

3.5 Ethical considerations

Many ethical considerations were made before commencing the study. The Metanoia Research Ethics Committee (MREC) reviewed the proposal and approved the study. A chartered psychologist and registered psychotherapist, providing useful space to discuss any ethical dilemmas, supervised the study. My conduct was guided by and in line with the BPS 'Code of Ethics and Conduct' (2009), The Health Care Professions Council 'Standard Of Conduct and Ethics' (2016) and the BPS 'Code of Human Research Ethics' (2014).

I considered the possibility of distress amongst patients in speaking about experiences, in light of the personal and sensitive issues of identity, trauma and others highlighted in the literature review. My strategy of recruitment from the Movement was deliberate, to reduce this likelihood of distress and ensure access to trusted supportive sources, in case of need. Although there were fewer ethical considerations involved in psychiatrists discussing their work experiences, there was some possibility of difficulties due to the difficult nature of psychosis. Exploring treatment experiences may evoke unresolved affect around suicides or other difficult incidents; as a safeguard, everyone was offered the opportunity of support from my research supervisor or me.

Chapter 4.

Findings**4.1 Summary findings**

The experience of conflict in psychosis treatment for both groups converged around four concepts, namely:

- **The need for meaning:** There is meaning in psychosis, with the illness developing out of life experiences. Search for meaning needs to be an important part of treatment but is not, creating problems for both groups.
- **The need for hope:** The experience of living and working with psychosis evokes feelings of terror and fragility and the fear that such feelings would last forever, making hope essential but a sadly lacking element for both sides.
- **The need for relationships:** Relationships are the necessary but missing conduit for discovering meaning and delivering hope. They are essential to soothing oneself in the terrifying quests that the patients must embark upon and psychiatrists must assist with.
- **The need for supportive systems:** Systems of treatment and psychiatric training that acknowledge and support the search for meaning and hope by providing the necessary relationships are essential. Without them, the quest cannot succeed.

In the tables accompanying each of the concepts, I produce examples of comments around these themes and my interpretation of how they interrelate.

4.2 The need for meaning

Patients focussed upon their need to construct a narrative towards greater self-understanding and complained about the lack of attention to those factors within psychiatry. Many psychiatrists in my sample also lamented this lack of emphasis upon stories in favour of diagnosis, misfiring neurons or misbehaving neurotransmitters. Some favoured the greater sense of professional and personal adequacy they gained in going outside their basic training to understand life and psychosis. In listening to both groups, questions arose about the existence of an inherent meaning in life and the human need to seek it. Whilst some psychiatrists in my sample understood the focus upon meaning as a reluctance to see the truth of humans as “just bags of

chemicals”, others were convinced of “an alternative psychotic world becoming necessary when living in the consensual world became too painful.”

Table 3. Illustration of the concept of ‘Meaning’

Concept: Meaning	Participant quotes	Researcher interpretation
Patients	<p>Psychosis about your lifelines being taken and you're feeling derailed “Bonnie”</p> <p>Recovery happens through sharing and learning, not ridding myself of experiences “Fay”</p>	<p>My psychosis was intimately connected to my experiences and feelings of terror and loss and I needed help to understand</p> <p>Making sense of my experiences is what I needed and did through the user movement, ignoring them as meaningless as psychiatry suggested was not the answer</p>
Psychiatrists	<p>There is a clear psychopathology, an organic or functional problem in psychosis “Keith”</p> <p>Our concept of human mind is more basic than a Volkswagen motor and there a mechanic has a more complex understanding than most psychiatrists have of the human mind “Hans”</p>	<p>Psychosis is a meaningless set of symptoms</p> <p>The human mind and psychosis are very complex but psychiatry insists on ignoring the complexity and the meaning that exists</p>

4.2.1 Patients’ need for meaning

“The whole experience of psychosis is so non-sensical...I was trying to explain but no one seemed terribly interested..I was surviving my time in hospital...it’s like all your lifelines have been taken away and..I was in a strange environment” (“Bonnie”)

Patients openly referred to their meaning-seeking nature and the need to reconnect with their lifelines, in the face of complete disorientation brought about by psychosis. All the patients alluded to links between their life experiences and psychosis development although they were not all able to be explicit about those connections. Confused by their experiences of psychosis and a lack of coherent narrative, patients hoped to work with psychiatrists to understand themselves. The lack of interest in helping them gain this self-understanding in psychiatry worsened the confusion, worry and anxiety about the threat to their sense of self. Time and again, patients expressed the need to explore their psychic depths and their place in the world.

The anxiety and disappointment in psychiatrists' failure in helping them or even to acknowledge the search was detrimental, as we see above and below.

"During my first breakdown, I drew a picture called "being collected", of me sitting in this chair on a hill...I was really chuffed because it expressed where I was at in the world, in my reality.....but.....never being able to talk about it wasn't good, you know" ("Jane")

Early physical and emotional maltreatment from mother led one to seek comfort from her friend, the Moon, through gaps in the coal-bunker she was exiled to each evening. Voices and visions started at the age of 4 and were directly linked by her to experiences of abuse at the hands of family and carers. Friendship with the Moon helped her cope with her painful reality because she escaped to the Moon during abuse and psychic self-attacks. Others also spoke of not being asked about their experiences of trauma or abuse, taking them away from self-experience and breaking the links.

"I remember hearing voices when I was 4. My mum was raped and I am what came out of the rape. Ummmm I only remember as far back as 4, the beatings, she would beat me up....The Moon became my friend because ummmmm I couldn't escape so I escaped to my head when bad things were happening and my mum was beating me up in the bunker, I wasn't in my body, I was on the Moon in a deckchair." ("Nicola")

Patients described early tendencies towards dissociation due to abusive experiences rather than learning to integrate body and mind. They reported hardly any exploration of such experiences or their mental distress or self-image during psychiatric treatment. This particular patient went into the care system after her mother's early death, ending up experiencing sexual abuse there and homelessness later, culminating in rape by a friend and a mental breakdown on the same day. Her psychosis was considered late onset and attributed to her first use of cocaine in her 30s, ignoring the history of early trauma, abuse, unusual beliefs and voice-hearing. Her work with the Hearing Voice Network opened her mind to understanding the impact of years of childhood trauma that she could then link to her rape, cocaine use and the

breakdown. Another former patient talked of early sexual and physical abuse at the hands of a carer from an early age. He heard voices and had strong 'delusional' beliefs, beginning and stopping with the abuse in early teens and reactivated with family responsibilities in adulthood. He too, did not connect his experiences until he questioned the "accidental nature of psychosis" within the supportive environment of the Movement. Others attributed their psychosis to early hurtful experiences and a lack of acceptance within their environment and themselves.

"I was a very angry child...yeah but I found that I suffered from... depression that I didn't accept so I fought it" ("Ben")

A look at the narrative of his life led one patient to conclude that early life experiences had left him very angry and depressed. Not accepting this reality had led to internal conflicts which tipped him into psychosis. He was aware of on-going internal divisions and distance from his own experience and criticised psychiatry for dismissing internal lives. He was pleased with the work he had done himself in searching for meaning which had ameliorated the impact of illness but felt he could have done better with more support. He believed that the, "reason I am where I am is because I have done a lot of soul searching" which "is the work psychiatrists try to dismiss". Patients firmly linked their psychosis to their quest for the soul therefore, seeing themselves as agents in life and dismissed the passive psychiatric view of illness as a biological entity entering from outside. They understood themselves to have developed psychotic ways of managing life due to explicit or implicit trauma and a lack of sufficient resources in their environment. The interviews provided evidence of a psychological journey among patients, moving away from the psychiatric narrative of meaninglessness towards meaning and context. All of them acknowledged that psychosis had brought difficulties, but also emphasised how it had directed them towards the richer life and self-understanding they now had. They criticised psychiatric practice for prolonging illness through inattention to subjectivity and meaning seeking and praised the Movement for helping.

"They are trying to be very rational, removed, looking in at a phenomenon, my symptoms.....to step in and see me as human, contradicts a lot of things really important to them" ("Fay")

Patients felt that psychiatric consultations focussed upon voices and other objective symptoms, ignoring their souls and humanity. Rather than attending to the effects of unusual experiences, psychiatrists were seen to be impersonal, in not paying attention to inner life or context. Patients felt dehumanised by the analytic, scientific, detached focus where symptoms and their severity were the phenomena of interest rather than the person behind them. Patients only recognised their own and the psychiatrists' indoctrination into the 'meaninglessness paradigm' upon encountering the Movement. They recognised the need to challenge medical orthodoxy upon noticing the positive impact of attending to their personhood, within the Movement. Patients such as "Fay" above felt pressured to disconnect from their experiences, reject the meaning seen within their heart or soul and accept the illness as a simple biological accident. Repeats of such experiences within psychiatric treatment left patients feeling isolated, despairing and un-understandable. Perhaps most damaging to the patients' sense of self was the feeling of being seen as only a set of symptoms, not simply human.

Once the patients came across the ideas of contextualised understandings through the Movement, they wanted to link their early experiences and psychosis. The psychiatric practice of breaking links between premorbid and morbid selves surprised them as if "it happened separately to another person that wasn't schizophrenic". As they understood how the early trauma had led to the need to create their psychotic world, the patients were puzzled and angry at the psychiatrists' refusal. As outlined, all of the patients were recruited through the Movement where seeking meaning and narrative is encouraged. Difficulties in seeking greater understanding of self and life within mainstream psychiatry led 5 patients into psychotherapy, a discipline devoted to seeking meaning.

"I thought there was a potential for understanding more about myself and be less overwhelmed, something missing in psychiatric treatment." ("Ann")

Evidence suggests a battle of wills between psychiatrists and patients with the patients burdened by "fears about seeking meaning in psychosis" amongst their psychiatrists. A classical ontological clash over focussing upon experiences in the depths of their 'being' versus the

tangible ensued. “Looking in at a phenomenon” isolated the patients from their own thoughts and feelings and left them helpless because they “knew” that distance was considered an essential part of the treatment. They wanted to explore those experiences from within but were disappointed at the explicit discouragement from actively participating in unfreezing their arrested development. Healing occurred through developing alternative understandings, rediscovering the forgotten past and constructing a new narrative. The “reluctance in psychiatry to acknowledge depth and meaning” was likened by patients to traumatic early experiences of being forced to accept other peoples’ truths. Unresolved parental traumas or non-resilient home environments with burdensome relationships were thus reproduced in psychiatric treatment. Patients spoke of creating an alternative world of psychosis since the original meaning was unacceptable to their young mind: “if I would have seen myself as being a victim and being powerless, I don’t think I would have coped so I found another way of me being powerless”. Through psychotherapy and the Movement, she developed an alternative view of psychosis as a “creative way of being helpless in the face of this huge monster that...possessed me”. The possession facilitated surrender to an alien force, easier to stomach than submitting to something human and was a way to cope with abuse and trauma. This patient understood her psychosis as a strategy to protect her family from her emotional needs, a tendency that could have been reversed in treatment if psychiatry had recognised meaning. By discounting the impact and meaning of traumatic experiences upon the mind, psychiatric practice was seen to discourage reaching out and seeking help.

“Doctors don’t acknowledge that they are coming across someone different, they see everyone the same way.” (“Ben”)

The mainstream psychiatric imperative of ignoring complexity and depth led to patients feeling unseen by their psychiatrists, fuelling animosity and conflict. Although patients acknowledged fears about exploring and understanding their symptoms, they were convinced of the existence of meaning in psychosis through experience in the Movement. The narrowness of ‘being’ within psychiatry meant psychiatrists were seen as lacking awareness of the rigidity of their approach. Through excluding aspects of being other than the biological and the tangible, patients felt they were related to as faults rather than people worthy of being understood. Within the Movement,

patients went through a process of conversion from positivism to interpretivism, from asking “what’s wrong with me?” to wishing to know “what happened to me?”. One patient participant insisted “my biology is not my biography”, complaining about the prioritisation of biology throughout his psychiatric treatment. A narrow medical focus with all individual, social or psychological factors taken out of consideration made psychosis similar to a physical ailment, such as chronic pain. Patients found their unique experiences were ignored in favour of a homogenised analytic understanding. Primacy of psychiatric knowledge and classification rather than self-understanding or individuality left patients feeling unacknowledged and dehumanised, making their humanity theoretical.

4.2.2 Meaning amongst psychiatrists

Complexity-oriented psychiatrists amongst my participants bemoaned reductionism in psychiatric rationales leaving psychosis entirely lacking in meaning and entirely explainable and treatable by pharmacological models. They pointed to “stuff like extreme family backgrounds like a very violent father gets downplayed and things like genetics get emphasised”. They focussed upon the contribution of the embodied relational, social and cultural and mythological natures of the human mind to psychic life. Such psychiatrists drew attention to the lack of focus upon the psychological and social in the mainstream, pointing out that those are precisely the aspects of ‘being’ that patients with psychosis are distanced from. They emphasised the need to acknowledge the impact of carers and the environment in forming an integrated individual and pay phenomenological attention to “repeated experiences of fear and terror of the loss of mind”. Whilst some recognised the complexity of our bio-psycho-social existence, they also expressed exasperation at psychiatry’s failure to grasp the nettle.

“...but our concept of human mind is more basic than a Volkswagen motor and there a mechanic has a more complex understanding than most psychiatrists have of the human mind. We have been stuck at the same level for a hundred years” (“Hans”)

There was obvious frustration about the mechanistic understanding of the mind and the lack of recognition of the need for a more complex model. All of those expressing such views had done psychological work upon themselves, with at least seven psychiatrists accessing personal

psychotherapy. They spoke of the need to become comfortable with the intangibles of human life, need for meaning and the impossibility of a neat, scientific psychiatry. For some the messiness of psychiatry created problems however, because they seemed to need clear causality, duality and tangible physical proofs. One spoke of moving from working with addictions to general psychiatry because he could not abide with ambiguity, preferring to work with clear medical illness instead of debating existence.

“I was much more interested in treating illness or psychopathology than with addictions... it’s hard sometimes to know...there’s even a debate in addictions....is the person ill.....are they ill or is it a social thing...is it....whereas its very clear that schizophrenia is schizophrenia.” (“Keith”)

This belief that everything significant was observable and not hidden, contrasted with the majority of psychiatrists who insisted upon looking behind the surface. For two, schizophrenia was a real disease, an objective entity obviously distinguishable from a state of good health that everyone else shares. In contrast, the majority of my sample believed that psychosis lacked clear psychopathology. The complex understandings of psychosis found in the literature review did not exist for these two, with a profound diversity apparent within my sample. The lack of attention to meaning and complexity in the mainstream led to complaints about the lack of sophistication within the discipline that we encounter above. A real split existed amongst psychiatrists interviewed with regard to the function of symptoms: as problems to be eradicated **or** pointers to the patients’ world-view and reasons for distress. Whilst some psychiatrists were keen to work with the psyche, others denied the existence of meaning or the patients’ search for it. In this regard, the same two psychiatrists spoke of “not looking for meaning in psychotic material” (“Doug”) and “people finding it difficult to accept themselves as bags of nerves and chemicals” (“Keith”). Another psychiatrist rejected this kind of simplification, expressing disbelief at the denial of meaning and simpler understandings of psychosis.

“that you can reduce something so complex....as somebody with a diagnosis of schizophrenia being unwell and everything that entails....and you can reduce that down to a word schizophrenia and medication.... to me...beggars belief really.” (“Dale”)

Those insisting upon complexity did not always have definite, elaborate theories but believed that more than chemicals or genetics were needed to understand people. There was a real split in understanding the individual and social aspects of psychosis: two believed it to be a biological disorder expecting clear organic pathology to emerge whilst most others cited the need for systemic, multi-dimensional models. Complex ideas about a “breakdown of common-sense understanding” or problems of “integration of the self” contrasted with a view of humans as simply “a bag of chemicals”. Some saw psychotic symptoms as patients’ “need to feel powerful through creating their own world” or “being at one with the symbolic” or “being overwhelmed due to the lack of protective armour.” For these psychiatrists, treatment required helping patients find meaning through understanding their own contexts that had made them seek protection and power in their symptoms.

“In non-psychotic disorders people suffer from reality....in psychotic disorders people change reality... to avoid the suffering even though the change might not be very effective.” (“John”)

Other psychiatrists saw these changes in reality as symptoms or deviations from the norm and simple signs of illness in patients, without inherent meaning. In contrast to the multi-dimensional models of psychosis used by others, a couple used single system models decried by “Dale” above, where biological dysfunction required permanent pharmacological treatment. Whilst some considered psychological work as essential to fan the fires of life and address the turning away from others, with drugs useful only in managing extreme distress, a minority saw drug treatment as the sole and necessary aspect. For some, constitutional vulnerabilities derived from both psychic and physical aspects making it difficult to establish a single cause. For some, psychosis was a simple biological dysfunction in need of attention, with psychological aspects mere epiphenomena. Whilst some could combine a biomedical understanding of psychosis with the breakdown of complex psychological scaffold of reality, a minority insisted upon the treatment for psychosis being no different, for example from that for tuberculosis (TB). Just as the typical symptoms of TB (chronic cough, haemoptysis, unexplained weight loss and physical

decline) are treated with antibiotics, nutrition and rest, the chemical imbalance in psychosis is treated without considering the psychological impact of the breakdown of the self.

“It’s a simple biological dysfunction in brain chemistry and although I can’t explain the physiology of schizophrenia...the simple medical model fits with an organic explanation.”

(“Doug”)

In contrast, other psychiatrists focussed upon patients’ need to rediscover meaning in life. They sought meaning in illness through attending to history and using their own subjectivity and minds to understand their patients’ withdrawal from reality. They placed a great deal of emphasis upon recovering motivation and inspiration in patients, with the loss of those aspects critical to the psychosis. There was a staggering diversity in the understanding of psychosis and its treatment within my small sample, with the majority of my sample feeling like a minority within the profession.

“I feel responsible to uncover the motivation....the fire in the belly...necessary for t h e patients to recover. The voices or delusions become the patients’ reality as they withdraw from social life and habituate to their psychotic experiences. In the process, particular neural circuits are recruited with those connections getting stronger, the longer the psychosis goes on.” (“Don”)

4.2.2.1 Cultural diversity and meaning amongst psychiatrists

Within my sample of psychiatrists, I felt that cultural and social values may impact upon meaning in psychiatric practice. “Gita” and “Raj” were both recent migrants from India who had done their basic medical training in India but specialised in England. They were the least experienced amongst the consultants and had experienced a strongly psychotherapeutic end to their mainly biological training. The ending had not been an active choice for either, but both spoke of having developed a very different attitude to treatment as a result of exposure to such relational training. They felt much more integrated as professionals through bringing the scientific training together with their personal philosophies and meaning structures.

“Giving them time, your ears, listening to what they have to say,...ummmm and seeing them feeling a little better at the end of that conversation....just gives you a satisfaction in yourself....just meaning in life I would say” (“Gita”)

Subjectively speaking, these two were more similar to the psychiatrists with significant personal experience of psychotherapy, in their ability to identify with patients and focus upon the human bond. The Indian psychiatrists in my sample seemed more focussed upon meaning and relationships than those without significant experience of therapeutic relationships. Doubts about the adequacy of the biomedical paradigm in attending to crucial human needs such as meaning were clearly expressed by these two. The attention paid to ontology in these two seems significant although I am unable to draw any firm conclusions. Cultural differences may explain some of their ability to question their previous learning within the biological paradigm. The concepts of “use of self” and “meaning” were used by these two and those who were consultants in psychotherapy but did not feature at all with “Keith” and “Doug”. Perhaps their openness to different conceptions of ontology derives from a complex mix of valuing depth and emotional connections, identity and a possible interaction with my own Indian background.

“I have felt the same thing, if I am bothered about something, I ... want someone just to listen, for me to just vent it.... to tell how I am feeling” (“Raj”)

I have evidence for radically different accounts of understanding psychotic patients and conceptions of ‘being’, with major implications for treatment. Psychiatrists with professional experience of exploring their emotions and sense of self seemed more open to seeking common ground and meaning with patients. They mostly shared a conviction that both patients and psychiatrists lose out through emphasising the objective and ignoring the subjective.

4.3 Systemic inattention to meaning

4.3.1 Patients

“They didn't find out why I was against it... basically they start running through...their framework and they don't step out of it.” (“Ben”)

In addition to individual differences in attitudes to meaning, I found evidence of systemic bias in the attention paid to the patients' need to understand their own lives. Through experiences in the Movement, the patients recognised the importance of journeying upon choppy existential waters and making links between their past and present. The systemic disregard of ontology meant that instead of the deeper encounters needed, they were offered an anaesthetised glide through a featureless landscape. They wanted to learn how experiences and interpretations might have contributed to their psychosis through a deeper engagement with self and others. Instead of better understanding their life and illness, they experienced rigid injunctions against seeking own meanings and pressure to accept the prescribed medical meanings. Patients had their own thoughts and feelings about psychosis and their treatment which were not asked about. Only certain ways of understanding were allowed without recognizing multiplicity and complexity. They wanted the psychiatrists to step out of the systemic restrictions imposed upon them to split patients' existence and listen to their experiences. The patients found themselves subject to a classification system instead of having their personal meanings and ways of relating to the world attended to. Patients asked for attention to their experiences and acceptance of their natural need to make sense of them but found the psychiatrists were indoctrinated into interpreting them narrowly. As they moved from questioning their older understandings of their experiences, the patients asked the psychiatrists to be open.

"What I would like though is to feel that.....when they ask me a question about what I was hearing that they are not just listening for the tickboxes, that they are actually listening to what I experience of it" ("Fay")

Patients were aware of the philosophical constraints of the system used and felt the aim was to make them fit the DSM template, not to understand them. They spoke of the impact of systemic lack of attention to depth and meaning in making them disappear from their own narrative, poignantly referred to by one patient as her "lost years". Whilst the Movement was seen to be empowering by helping them look for meaning in their own experience, the psychiatric system was seen to disempower. The Movement was helpful in letting patients connect their past with their present and they criticised the profession for attempting to break such links. They

considered the system to be too inflexible and too focussed upon the tangibles, unable to incorporate the possibility that trauma may have affected them for decades before manifesting obvious distress. These difficulties were seen as evidence of institutionalisation of the mainstream understanding of psychosis in training, not just attributed to individuals.

4.3.2 Psychiatrists

“The split in faculties in Royal College...between psychiatry and psychotherapy...sends the wrong message. If one believes that you can’t make sense of madness....that there is no meaning then you are just going to reinforce the theory of random consequence and that gets institutionalised and harms everyone” (“John”)

The institutionalised split between paradigms of meaning and meaninglessness was put forward as a problem at the heart of the profession. The implied lack of a common ground led to psychosis being incontrovertibly biological chance occurrence **or** an illness with individual psychological meaning, with **no** overlap. The consequent lack of discussion reified these positions and harmed everyone through stalling any development. Some psychiatrists recognised the harm to patients through the imposition of meaninglessness upon experiences and the loss of agency, leaving regime compliance as the only option. Those psychiatrists with experience of alternative paradigms and the ability to contain their own and the patients’ anxieties questioned the adequacy of mainstream psychiatry.

Other psychiatrists acknowledged the harm from systemic splits in training and service provision, preventing exposure to a comprehensive picture of psychosis. The suggestion was that not only did these splits misinform, they led to institutionalizing the divisions. Psychiatrists and patients were harmed by the inappropriate splits of the illness into acute and remission phases, which made it difficult to understand the total experience of psychosis. The institutionalised split determined psychotherapy as entirely different from medical treatment and ‘remission’ to be categorically different from the acute phase. The difficulty in bringing together the art and science of psychiatry was reported to lead to the splits within the profession and between patients and healers.

“The separation of services into community and acute wards rather than following people through is unhelpful in giving an incomplete exposure to psychosis. Perhaps the skewed experience of psychiatrists leads to the splits and polarisation because the bigger picture is not being seen.” (“Seth”)

Those psychiatrists with experience and understanding of modes of ‘being’ other than the scientific, compared their experiences of more biomedical treatments with deeper therapeutic ones. They gained greater satisfaction in work, felt more committed to their patients and knew the patients benefitted from the different attitude. They also reported that such deep engagements with the patients’ life ‘quests’ demanded much more from the psychiatrists than the simpler psychopharmacological restoration of functioning. Going into the patients’ depths inevitably meant an engagement with one’s own psyche which not all psychiatrists were trained for or comfortable with. They could therefore see the lure of immediate rewards in managing symptoms instead of the search for meaning by working on “something more”. In addition, they conceded the systems were constructed to reward the more superficial interventions for “reasons of reduced cost and measurable effectiveness”.

“Psychotherapy is intensely fulfilling and satisfying but to try and really get to understand somebody is a long process with uncertain outcomes, long periods of anxiety....The other side of being a doctor has a more immediate rewarding feel to it....but it is a treadmill type of relationship without the potential to work on something more in their treatment.” (“Len”)

Although some psychiatrists felt a greater professional sense of security in negotiating uncertainty and ‘using their self’, systems of professional training and provision directed them towards a narrower existential focus. The systemic pursuit of simplicity appears to have led to an overvaluing of certain aspects of the work and created a disease within the profession. The evidence suggests that, psychosis as a meaningless phenomenon where the patient is a passive object rather than a subject in need of support, satisfies neither side.

4.4 The need for hope

Patients referred to the difficulties of living with psychic storms and the overwhelm which is characteristic of psychosis. Most of the psychiatrists talked of their own fears and dread in working with overwhelmed patients in the middle of losing their sense of self. In managing these problems, both groups referred to the necessity for hope as well as the difficulties in remaining hopeful, for a range of systemic and individual reasons.

Table 4. Illustration of the concept of 'Hope'

Concept: Hope	Participant quotes	Researcher Interpretation
Patients	Mental illness is messy in real life, not neatly categorized and in line with scientific criteria "Amy" Psychosis has aspects unrecognized & feared by psychiatry "Ben"	Psychosis is a lot more complex and fear provoking than acknowledged in the mainstream. Psychiatrists' difficulties with these fears prevents them from helping us move towards hope.
Psychiatrists	Possibility of intense & personal connections draw you in (to psychiatry) but reality very different "Len" Distance from patients is a defence of our personality, against realising you know fuck all "Don"	We come into psychiatry to relate but the difficulties mean we adopt professional personas to deny our own and patients' fragility and distance ourselves from the hope we all need but lack.

4.4.1 Patients' need for hope

"I was in three or four different hospitals.... there was a feeling of there not being any hope, I was never going to get any better..." ("Bonnie")

I have earlier presented evidence about the patients' need for meaning in their experiences, it would seem that hope is essential to engaging in that search. In psychosis, patients constantly lived with the fear of psychic annihilation and needed hope and sustenance from carers. Most patients reported having their diagnosis delivered with a sense of hopeless finality so they were no longer expected to have meaningful lives, at work or in relationships. The difficulty of living

with psychosis and the lack of hope of any improvement made them question their purpose and worth in life. The corrosive impact of the lack of hope and meaning made it much more likely that the psychiatric prophecy would be fulfilled, by the patients giving up their search and stagnating.

Treatment seemed to aim simply at facilitating the continued existence of the body without any focus upon reconnecting with feelings, the spirit or deeper aspects of life. Patients perceived eternal hopelessness pervading the treatment due to a permanent, ineradicable fault in their brains and a lack of space for alternative understandings of psychosis. Having approached psychiatry with an expectation of answers to questions and help with charting a desirable life, the patients' found the questions were shut down and their search for meaning aborted because their "brain was broken". Meaning and hope seem entwined in this regard with the patients recognising that their first task was to transcend the meaninglessness of psychosis, and feel hopeful again.

"Life is just going to be full of horrible, frightening experiences.....and very little else and I needed to think that there was some other possibility really." ("Ann")

Patients wanted greater understanding of and an improvement in their circumstances, instead of one psychic crisis following another and psychiatry could not offer them that. The lack of meaning in life or psychosis in the psychiatric discourse, with the illness seen as an irreversible biological accident contrasted with the message they heard within the movement and psychotherapy. After years of a narrow and hopeless existence, patients were attracted towards a different narrative. This necessity for hope and "soul-searching, the work that psychiatry dismisses" as one called it, helped patients to re-engage with their own psychic process and took them into the Movement.

4.4.1.1 The Movement and revival of hope

It would seem that patients experienced psychosis as a threat to the metaphoric inner light or flame, guiding them in their life's quest. The disregard of the light or hope in psychiatry was therefore seen as a further threat, as an injunction to accept defeat. At this point, patients

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recognised more of their needs and the necessity of personal effort by themselves and others (the Movement/professionals) to help patients rekindle the flame of life.

“You have got to look for that light because I don't think anybody's light has totally gone out, the flame is still burning somewhere but it's about giving a little bit of yourself.” (“Keats”)

Patients complained that the psychiatric emphasis upon meaninglessness resulted in hopelessness and blowing out the flame of life, rather than helping it survive. Lack of attention to the need for connections with the self and others and the hopelessness of the ‘diseased brain’ label were contrasted with a transformation of their sense of self and recovery of passion and hope within the Movement. As a result, they now understood more about their path into and possibly out of psychosis. My sample had all experienced mainstream psychiatry and whilst a minority (two out of nine) had entirely rejected it, seven were still engaged with it and the Movement.

Patients believed that most psychiatrists were unable to provide hope because their model of understanding lacked hope of recovery from psychosis. This rejection of complexity and the need for hope within psychiatry was contrasted with the acceptance found within the Movement and welcomed by all patients. Patients spoke of their efforts to gradually rebuild their selves after years of negative self-perception through the simpler view of psychosis. Regular attendance at groups such as Hearing Voices Network helped them gain validation for their experiences and personhood. Patients felt able to slowly regain self-respect through affirmation from others of “the voices being real” or that “hearing them doesn’t mean I am irredeemably mad”. They could chart significant stages in their recovery by their ability to explore more of their psychotic experiences within the Movement. Patients spoke of having a wider range of conversations within the Movement about complex aspects of existence, something they discovered the professionals were unable to do. This ability to process and understand was favoured against experiences left unprocessed and unintegrated in psychiatry. Acceptance from others gave patients greater self-understanding and self-acceptance, which in turn gave them

hope to continue. The ultimate cost of the lack of hope was an inability to sustain oneself through persistent psychic storms and fears of disintegration.

“It is important to accept a whole person, not just an aspect of the person that you can handle. Workers need to be able to explore things fearful for them to go to, to go to a deeper place...Since being able to talk about experiences and various levels of existence, I’ve felt whole.” (“Jane”)

This clear need for acceptance and dialogue in moving towards wholeness derives from patients’ experiences of the necessity of exploring the unbearable and regaining hope. Several of the patients spoke of their understanding that the psychosis had begun due to some very difficult experiences within their family system. In order to recover, they believed that they needed to integrate the impact of the trauma upon themselves. Patients needed staff to be aware that the workers’ own theoretical and personal biases could turn something “difficult to bear” into unbelievable. Consequently, the patients felt that post-diagnosis, they were seen as discredited witnesses within psychiatry, every utterance a product of their madness. Their journey through psychiatry repeated these early difficult interpersonal experiences by delivering hopelessness, making them feel bad and flawed. Being listened and attended to within their new family system i.e. the Movement however helped generate hope. They were heartened to see the problems of psychosis transformed into a skill and a useful perspective when they met others who had not let their illness define them.

“I felt fundamentally flawed... like you know there was....aaaahhhh.... that there was no hope and no future and that I was bad. Something about me was bad and with the group there were people that I respected and I came to really admire who had similar issues to me and...they were coping differently” (“Nicola”)

Gaining alternative understandings and reviving hope through the Movement helped patients cope better with the psychotic storms that had destroyed them in the past. Contact with people in recovery from psychosis who managed their experiences well, sometimes without psychiatric intervention, opened up doors that had not existed. Patients could now entertain not just the

possibility of recovery from and management of their psychosis but that of seeing themselves as worthy. All reported experiencing a positive feedback loop through involvement in the Movement, an improving self-image and moving away from the paradigm of hopelessness and meaninglessness. They felt able to challenge internalised stigma and negative self image and imagine a brighter future. Patients who had seen themselves and all psychotics as losers learnt to see them as heroes through surviving adversity and negotiating change of paradigms. Admiration for someone with psychotic experiences, an impossible and unimaginable idea until then, now became possible. Peer support in a facilitative environment brought a new lease of life and a recognition of the learning to be had in psychosis, another unimaginable idea. The Movement brought them back into the orbit of life from the limbo of psychosis and the psychiatric model, through rediscovering hope and the relevance of their past.

“If I was in a different situation and I hadn't learnt all those things then perhaps the same dark places would last just as long and they'd just be as all consuming but whereas now I am able to get myself out of it more” (“Fay”)

Through understanding their inner life, patients gained hope and accepted the existence of darkness within all humans and the need to travel that terrain. Such experiences helped sustain patients because they could now see life as a quest, without feeling disabled and crushed by the nihilism of psychiatry.

4.4.1.2 The impact of lack of hope

Having travelled some distance on the path towards self-understanding, patients also gained some awareness of the emotional impact of the lack of attention to hope and meaning in psychiatry. They recognised a previously unconscious hopelessness and loss of direction together with a need for others to help them get back on track. Experiencing the rejection of this deep need produced anger and frustration amongst the patients, possibly adding to the hopelessness.

“I used to come away absolutely furious and I could never work out or it took me a long time to work out why it was. It's because I was kind of going into each time, thinking he's

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going to make everything alright now and when that didn't happen, you know, he'd just say keep taking the tablets and come back and see me in 'n' weeks" ("Amy")

Such evidence of frustrations amongst patients with their psychiatrists' failure in providing or even recognising the importance of hope led to irritation with mainstream models and a search for alternatives set in. All the patients reported similar disappointments and that their ray of hope came through other professionals or from within the Movement, not psychiatry. Encountering a different paradigm made them sensitive to noticing the differences in environment, resulting in a growing awareness that they felt unsafe within the medical model.

"really important to have some idea that things could get better, not I suppose not necessarily that....they go back to the way they were or that...you know all the things would just go away...it was more like that I could feel more...more in control of my life cos it just felt like things were completely out of control really, unsafe...so I suppose I just wanted to hope to feel safer...." ("Ann")

The longer the treatment went on, the more unsafe the patients reported feeling due to the meaningless and hopeless psychiatric narrative. In contrast, they met people they admired within the Movement who lived more fulfilling lives. They noticed the existence of a range of narratives around psychosis, with those in the Movement feeling better held by contextualised narratives and with greater hopes of recovery if they processed those experiences. Others living solely within the psychiatric model, however, lived with a narrative of unpredictable biological accidents, limited symptom control and severe side-effects from medication. Persistent psychotic experiences and on-going psychological fragility even in treatment made it difficult for patients to imagine a better future. They felt blamed for lack of compliance with treatment during turbulent periods in their lives, leaving them feeling more unheard and misunderstood. The lack of hope and sustenance from the treatment led to their feeling out of control, lost and fundamentally flawed. In this climate of hopelessness, psychosis became more terrifying and intolerable and patients complained of psychiatry's inability to soothe.

4.4.2 The need for hope in psychiatrists

4.4.2.1 Fear and fragility at core of psychosis

“How exhausting and hugely frightening...to listen to someone in acute psychosis and you wonder about your own hold on reality slipping and how they might fit you into their delusion. Not everyone can stand that.” (“John”)

All of the doctors spoke of dread, fear and fragility dominating their work and contact with psychosis. There were major additional worries about the greater risk of suicide in psychotic patients. The psychiatrists therefore recognised their own need for a hopeful narrative in working with psychosis, for a worthwhile future for their patients and own ability to manage the inherent fears. I noticed very different ways of working with such difficult emotions; the first being to understand and work with the phenomenology of psychosis whilst the second was to ignore their own or the patients' experiences. The first group, “John” being one, had significant experience of modes of ‘being’ other than the scientific and recognised human needs for meaning and difficulties with the ‘quest’. The second group took the positivist view of focussing upon the tangibles of psychopharmacological restoration of functioning and ignored the intangibles of depth, feelings and meaning. A third group with limited exposure to psychotherapy, existed in the liminal area, holding phenomenology to be important but lacking a clear strategy on its use. The first group used the therapeutic relationship as the focus of their treatment, seeing it as the conduit for instilling hope and changing mental structures. They used good therapeutic relationships to understand patients and medication to manage the anxiety and other safety issues, arising during the process of change. For the second group, the hope of managing their own fears and those in patients derived from their belief in restoring functioning through medication, without bringing meaning into the narrative. There seemed to be a clear correlation between the psychiatrists' understanding of psychology and the focus of their treatment, with the relationship being the main treatment for the first group and pharmacology for the second. The first worked with the patients to decipher the language of psychosis, the second stayed loyal to their biomedical training in focusing upon overt pathology whilst the third struggled, noticing patients' unmet needs and doubting the adequacy of their training. Whilst the need for hope and reward were common to all groups of doctors, the first

used their capacity to tolerate anxiety, fragility and dread. They expressed frustration at the second group's failure to look for meaning or link own feelings to those experienced by their patients, attributing it to the neglect of those aspects in medical training rather than being an individual issue.

Psychiatrists who had not travelled terrains other than their mainstream training seemed to end up isolated from other professionals and patients, without recognising it. My subjective feeling was that the most biomedical of my sample were more hopeless and less engaged with their work, as they seemed unable to cite live examples in the interview. Other psychiatrists provided clear cases and examples of their ability to carry hope for patients as well as an intimate embodied understanding of the psychotic process. Their capacity for 'negative capability' seemed to help sustain them whilst the others focussed upon technological interventions. The first group focussed upon their "responsibility to reveal and fan the still burning fires of life in the patient and provide help to keep them going" and the patients' need for self-understanding. In this context, a facilitative relationship between the patient and psychiatrist was considered crucial to alleviate the risk of a psychotic collapse.

"Patients feel involuntarily pressed into another form of existence and it is my job to build a bridge of understanding between the patients' world and my own. My role is to provide hope you know.....bridgebuilding....put a stop to the interruption of feeling and functioning and bring them back into relationships...recognising that there are factors keeping them stuck in psychosis." ("Hans")

There was remarkable congruence between some psychiatrists and all patients on the need for the professionals to carry hope when the patients were unable to do so for themselves. Here, the psychiatrist assumes greater responsibility for developing and maintaining the relationship because the psychotic patient is seen to be in despair and in need of support to come back into contact. The major difference between the groups seemed to be about their understanding of the role of relationships, with the first seeing their main function as carrying hope whilst the second saw them simply as ways to convince the patients to comply. The single discipline psychiatrists may have adopted the simpler mainstream model to help themselves feel more

hopeful because they seemed less confident of their ability to bear the fullness of psychosis in relating with patients. Instead of connecting with the bio-psycho-social complexity like the first group, meaning, hope and relationship were exchanged for a singular focus upon chemical imbalances and denial of all alternatives. This acceptance of the simpler understanding of the medical model may be connected to their need to avoid the patients' bottomless pit of emotional needs. Comments from these psychiatrists of helping patients live the best life they could sounded like an acceptance of the loss of the patients' personhood, leaving behind a husk. I found evidence for some internal pressure to value the scientific paradigm by making it into a technical issue rather than a human one.

"I have never met anybody who has a more.....ummmm who is able to express a more consistent alternative way of doing it really. Even people like.....social workers and nurses, if you actually asked them...I think they would come down to these models which are around....you know what we do to people, they are not so much about how...we want to live with them.. form a relationship with them." ("Doug")

For this particular psychiatrist, firmly in the second group, his task was "to do things to patients, rather than learning to be with them". He acknowledged that his focus was to "eradicate symptoms or fix" his patients rather than trying to understand them or helping them learn to live with them. The urge 'to fix' focussed upon chemical imbalances or structural faults, suggesting a very different relationship or narrative from that of building bridges of understanding and bringing patients back into relationships. The contrasting narratives were of a classical technological medicine versus the hallowed holistic medicine where all aspects of human life are considered. In absence of a focus on inspiring hope, the work became about fixing faults in the brain and doing things to people rather than understanding and being with them in their struggle. I was particularly intrigued about his claim of never having met anyone with an alternative way of working because a psychiatrist in his team had written a well-known book emphasising psychotherapeutic relationships. Perhaps technological medicine seduces through facilitating avoidance of experiences of uncertainty and anxiety. It would seem the task at hand varies, depending upon the prevalent attitude in the mind connected to that limb.

4.4.2.2 Managing the feelings

A qualitative difference in attitudes to feelings in work with psychosis between the two groups came to light that might help us understand the differences. Most psychiatrists spoke of something akin to dread or fear and indescribable fragility whilst the two most positivist ones (“Keith” & “Doug”) did not refer to any such thing. In fact, the same two denied differences in affect between the experiences of treating psychosis and other serious mental distress. All the others recognised something categorically different and overwhelming in working with acutely psychotic people and a consequent temptation to simplify or shut down the work. The more biomedically inclined two, did not seem to notice the vulnerabilities and fragilities inherent to psychosis for all others. They acknowledged that others found working with psychosis “dismal and depressing” but that had not been their experience.

“I don’t think so...ummm I wouldn’t think any special...i think its similar....because the thing about schizophrenia is that the patients can be depressed as well, there’s a whole range of symptomatology so and even...ummm the diagnoses are kind of fluid so I think its difficult to therefore discriminate....between the different sort of feelings and relationships.”
 (“Keith”)

It was difficult to reconcile the two statements directly above, “John’s” exhaustion and fearfulness in relation to psychosis whilst “Keith” found no difference between working with it and depression. Most of the psychiatrists acknowledged the inherent difficulties in the task and the unusual amounts of energy needed to interact and engage with patients in acute psychosis. They recognised that not all psychiatrists were willing or able to deeply engage with patients’ processes of fragility and terror of psychic annihilation due to the contact with their own fragility. This interpretation, put forward by the first group, was rejected by the second. The first group understood the difficulty to be a testament to the dread of hopelessness at the core of psychosis, making technical engagements with patients’ bodies attractive. In that vein, “Keith” and “Doug” were the only two to believe in medication being sufficient and necessary treatment. It seems therefore that facility in working with difficult emotions informs the psychiatrists’ ability to perform their role. In absence of such facility, some psychiatrists chose to detach from their patients’ needs and their own feelings and saw psychosis as a simple medical problem. Instead

of carrying the responsibility for a narrative of hope and bearing the inherent difficulties of the task, attempts at self-protection and cynicism were condemned.

“You shouldn't be a psychiatrist if you are a cynic.. because you will not come close to people, you will use over-simplified categories to do away with human situations, maybe to protect yourself or whatever....It would really be damaging to everyone.” (“Hans”)

Psychiatrists' difficulties in managing own emotions may result in unconscious choices to abandon patients damaging both parties, providing more evidence for the role of emotions and deeper attitudes to self and others in understanding psychosis. Some of my evidence was indirect, as above, with some psychiatrists' denying differences that were obvious to others. There were many direct expressions of doubts about the extent of understanding psychiatrists had of their patients and wishes for them to develop their capacity for the work and engage with the bleakness of their lives. There was some recognition of the impoverished nature of patients' emotional lives but the reactions to this impact of psychosis were instructive. Whilst for some, poverty of affect and relationships were characteristic of the psychopathology in psychosis and a target for treatment, others implicitly accepted them as the natural course of the illness. For this latter group of psychiatrists, there was a lack of imperative to engage with and change the situation for patients because the diagnosis itself was hopeless. This easy acceptance of the bleakness of diagnosis made some wonder if it was easier to maroon the patients because of the difficulties involved in using one's self to tackle the hopelessness.

“there's not a kind of imperative to change their (impoverished lives).... the way there would be if someone had a leaking tap.....it's not easy to change....because as a group they are...resistant to that kind of emotional engagement and....so it's not...I am not saying it's easy to do....but it's striking that there is an acceptance of it.” (“Seth”)

The typically deep-seated intractable issues of psychosis seemed more manageable within a bio-medical discourse because emotions were not involved. Some psychiatrists acknowledged that the “training does not prepare us to support the patients sufficiently” but those with specialist psychotherapy experience had developed this ability. They compared the respective

emotional burdens of working with psychosis with those of personality disorders and gave preference to the latter as they “have greater possibility for emotional engagement and hope of recovery”. It was also acknowledged that it was “easier to measure treatment success by time out of hospital rather than patients’ sense of purpose, quality of life or relationships”. It would seem that the emotional impact of the work affects the psychiatrists’ choice of models. Whereas the first group saw the job to be about managing their own feelings so they could model the task of bearing the unbearable for patients, the second group either did not notice or dismissed the feelings as meaningless, requiring no personal contact with patients.

4.5 Systemic neglect of hope

4.5.1 Psychiatrists and the systemic neglect of hope

Most psychiatrists recognised that training affected their understanding of and the need for hope they carried about diagnosis and treatment. They attributed the lack of attention to meaning, hope or the patients’ psyche in the mainstream model because biological faults rather than psychological pain and distress were targeted. The medical model of psychosis meant that for mainstream psychiatrists, the focus of most appointments was the patients’ struggles with taking medication. This lack of attention to the existential issues or the psyche led to a hopeless “treadmill of treatment”, amongst those staying within that model of psychosis. Once psychiatrists had discovered clear clinical reasons for exploring patients’ psychological experiences and distress, they were much more excited about being involved with their patients. One spoke of her greater sense of hope around psychosis and a change in how she viewed patients, after some psychotherapy training. Once she had encountered alternative understandings, she could see her training had disallowed holistic connections with her patients. Remembering her lack of hope upon coming across symptoms of psychosis in a patient early in her training, she reflected upon how she might react now due to recent learning and internal changes. In that instance, she had felt sadness about the effective end to the 17-year-old patient’s life because it would simply “consist of horrible experiences and a lifetime on medication”. Her current deeper understanding made her much more hopeful, making it impossible to imagine that such internal changes would not impact the treatment, therapeutic relationships and the attitude transmitted to patients.

Findings

“But inside I was feeling very sad. But nowI think even inside I will be very hopeful, not just on the surface.....because I do feel positive about it because I feel....that even if you know she has these voices for the rest of her life, she still has a life. ummm....and she can function and she can do.....what other people can do who don't have voices....so that is a change in my concept about.....schizophrenia.” (“Gita”)

My data suggests that psychiatrists need to carry hope for their patients but are held back by the lack of help from psychiatric training with this aspect of their role. Exposure to alternative disciplines of psychotherapy helps them understand more and feel more capable through developing interpersonal skills. These psychiatrists seem to undergo a process of change and enter a liminal space, where they move from a singular focus upon biology and technology towards adding human connection and psychological understanding to their skill-set. Psychiatrists felt empowered through developing these abilities and spoke of being impoverished without them in the past. They spoke of the discovery of these new tools within themselves as enabling them to counter the hopelessness, fear and fragility of work with psychosis. A greater ability to use their ‘self’ and better understanding of psychosis through training and self-experience helped them carry more hope for their patients. Such psychiatrists, aware of the need for meaning and hope, believed their work carried more healing power because they felt a greater commitment to their patients. They favourably compared the in-depth understanding gained through working in therapeutic environments and lamented the lack in basic psychiatric training.

“Relationships with patients in psychotherapeutic milieus lead to an understanding of a depth that can't be imagined in usual psychiatry and.....make you a great deal more committed to them.” (“Len”)

I have significant evidence for psychiatrists being held back by paradigm constraints in their ability to understand patients and themselves and provide the requisite hope. Some of the participants pointed to these shortcomings and acknowledged their “fears of going beyond acceptable medical practice”. They spoke of colleagues being attacked for “alternative understandings of psychosis’ and attributed the intolerance to “insecurity within psychiatry about

its own evidence base". Some worried about accusations of "engaging in psychotic thinking" when speaking of a "non-verbal rapport with patients" or phenomena such as projection or introjection. A lot of rigidity seems to exist in the system, forcing people to practice at the "lowest common denominator" and experience fear when seeking answers outside recognised parameters. I found evidence for such fears when intolerance and threats of exclusion were shown in discussing deviations from consensual practice. The 'us and them' divisions provide a sense of the threat to identity that is experienced when personal and professional systems are challenged.

"I just ignore them...(the patients and carers) but when it's one of our own, a doctor disagreeing with or attacking the consensual understanding of psychosis, I do wonder why they are doctors really?" ("Keith")

Participants seemed to assert their power in ignoring demands from patients and carers for a holistic system, showing rigidity and fundamentalism through a narrow practice of psychiatry. The complexity of psychosis and need to carry hope for patients were dismissed in favour of biochemical imbalance theories whilst the patients and carers questioning the model were dismissed as "knowing nothing" and the doctors as traitors. Holding on to hope seemed important to both groups of psychiatrists but divisions appeared on the reasons and methods for doing so. Whilst some held on to hope as a necessary part of treatment and through continuing to learn, others insisted on staying within the bounds of original learning in order to maintain own identity. Systemic constraints may be distorting the vocational priorities of some by making them feel unsafe in venturing outside consensus and attacking those who do.

4.5.2 Patients and the systemic neglect of hope

Patients told me that mainstream psychiatry did not provide them with the requisite sense of hope or meaning because instead of understanding, it focussed upon reducing symptoms. They felt their role within that system was simply to describe their symptoms whilst the responsibility to devise and evaluate treatment lay solely with the psychiatrist. This strict division of labour meant that the patients' need for hope and meaning did not feature in the treatment, making them turn to the Movement once they had lost hope in the system. One patient spoke of the

help she received from family in managing anxiety about others accessing her thoughts whilst on the train. She was advised to travel with her favourite music playing in her earphones so that others would not be able to distinguish between her thoughts and the music. She contrasted the way her worries and need for self-understanding were taken seriously in this interaction with their relegation and neglect in favour of the systemic need to reduce risk. She felt heard when her personal meanings were engaged with and she gained hope of wresting control over her own thoughts and processes. She contrasted the unhelpful responses from psychiatrists in dismissing her worries whilst emphasising their own professional needs to manage risk and gain her compliance with medication.

“that was what I needed, a creative way around it to help me get control again whereas the normal response was.. kinda’... that’s a delusion...(laughing) some kind of you know...would you go back on your medication (laughs again) we are quite concerned about your risk levels..... kinda’ conversation which is less helpful to me” (“Fay”)

Patients knew that their symptoms were not real but they wanted recognition that the effects were real and asked for the psychiatrists to recognise that distinction. Patients felt that the psychiatrists were caught in a paradigm where their need to dismiss symptoms as unreal trumped patients’ needs, scientific objectivity mattering more than subjective reality. Further evidence came from patients’ complaints about the design of the system being more in line with professionals’ needs, not those of patients. Difficulties with trust and fear of vulnerability were prominent in psychosis, with patients aware of the need to face them in order to integrate their selves. They complained about the expectation that patients trust the system instead of being provided with individuals sufficiently trained to meet their needs, because the system did not recognise the impact of interpersonal trauma upon ability to trust. Patients recognised the need for a therapeutic relationship to be the conduit of hope but psychiatric division of labour prevented it.

“but there is this kind of unsaid thing, talking goes here, medication goes here.....so it’s compartmentalised and then my current care co-ordinator does not feel qualified enough to do any kind of proper counselling so these things come as separate bits” (“Amy”)

Patients suffer, with system design contributing to and continuing the split in their 'being' instead of helping them heal from the trials of psychosis. There is a certain irony in this systemic tendency to split when patients need it to carry hope and provide the necessary tools to bring their selves together. Such experiences of disappointment led to conflict with psychiatrists as the patients found no reason to look towards life and others until they encountered hope and meaning through the Movement, as we discovered in earlier sections.

4.6 The need for relationships

Patients recognised their need for relationships and safety through noticing the lack of hope and meaning within psychiatry and rediscovering those within the Movement. They felt able to construct a narrative of their journey by learning about the links between psychosis and their experiences, through relationships. Amongst the psychiatrists, I found evidence that some looked for and found meaning and fulfilment in relationships with patients whilst for others, such needs were insignificant. Whilst all the psychiatrists in my sample were attracted to relational engagement, it would seem only some recognised the complexity and the difficulties involved.

Table 5. Illustration of the concept of 'Relationships'

Concept: Relationships	Participant quotes	Researcher interpretation
Patients	<p>Too scared to have my needs met in case I never want to leave "Amy"</p> <p>I know I want & need relationships but they don't and that's confusing "Fay"</p>	<p>Healing in psychosis happens through getting to know myself and others better but that is too scary so we ignore the need.</p>
Psychiatrists	<p>Working with psychosis was a pit of unmet need and exhausted me and possibly why I moved to more functional models "Len"</p> <p>Most... people who develop schizophrenia...their personal histories...something awful happened in their personal lives.. I wonder how prepared are people...to use themselves...to face this trauma... to share the trauma..... I wonder if that ...becomes a barrier? "Gita"</p>	<p>Working with psychosis is emotionally exhausting and the system allows a way to distract self.</p> <p>Psychiatrists may not feel sufficiently equipped to work with the difficulties of work with psychosis for personal and professional reasons.</p>

4.6.1 Patients' need for relationships

Patients spoke of inadequate relationships within psychiatry reflecting earlier difficult relationships with self and others whilst positive personal experiences in the Movement helped them. All of them spoke of the importance of peer support in psychological growth with their experiences being taken seriously within networks such as Hearing Voices Network. Through experiencing empathy within the Movement, patients had come to recognise the complexity of their selves, reflecting the premise of intersubjectivity. They spoke of the importance of making links between their past and present and the costs of facing workers who could not help them with the difficult psychological work. They had expected psychiatry to have a holistic view of human nature but felt even more alone throughout their treatment. They spoke of their un-lived lives in psychosis, linking them to their sense of isolation and distance from self and others and the lack of affirming relationships. Without such relationships, the therapeutic work of directing attention to feelings and strengthen patients' sense of self could not happen which made further escapes into psychosis more likely.

"They were not present to me because they weren't present to what was going on in my world at that time. Now, I don't feel like my years are missing....and...you know....I could argue that maybe that..... well that's because I am able to talk about it" ("Jane")

Through experiencing validation within the Movement, they understood the impact of its lack in their past. Patients felt more present in their own lives when connecting with others and absent or missing in action when they felt less validated and connected to by others. In a way, they became more conscious and aware through recognising the impact of others upon their psychological process. Some connected their sense of not belonging in the world and feeling worthless due to early interpersonal trauma and how those beliefs were challenged through the Movement. Patients spoke of their gradually increasing ontological security through such involvement, which in turn helped them in exploring their thoughts and beliefs further. They contrasted this sense of safety in exploring feelings and thoughts within psychotherapy or the Movement with its lack within psychiatry. Several examples were given of the necessity of freedom to speak safely about difficult feelings and links between such conversations, psychological growth and recovery. Patients experienced the shutting down of conversations

due to fears in staff when topics which “aren’t usual subjects of polite conversation” arise. They reported that the focus of relationships within psychiatry was compliance with medication or treatment, not to safely explore their fears and concerns. Problems worsened due to experiences of disrespect and disregard in psychiatric treatment. The categoric dismissal of the reality of voices and other beliefs for the patients together with the lack of collaborative relationships and solidarity made them feel under attack from their purported healers. They reported internalising of even lower self-worth through repeated experiences of being dismissed and not being listened to, losing the battle of wills with their healers.

“You tell them what you feel or hear and they just say, it’s not real, it’s only in your head. Well, it’s real for me.....on top of all that....they kept giving meds for years that don’t work, you tell them and they don’t listen so you end up feeling like shit” (“Nicola”)

Patients gave several examples of increased attacks upon the self or lowered self-esteem, as in “voices got worse when I was treated like a child and asked to leave consultations”. Some spoke of their fears about staff abusing their power and position, giving examples of everyday treatment re-traumatisation through invalidation, reflecting findings from survivor literature. All of them reported a lack of healing relationships with their psychiatrists, creating a devastating mixture with the fragility and ontological insecurity of psychosis. Insecurity and lack of trust in self was made worse by the dismissal of patients’ reality or experience by professionals who deemed them unworthy of care. In the process of battling against the forces of disintegration in psychosis, patients looked for support and strength but found cruel and alienating disregard. This denial of needs and experience of psychiatry as a malevolent authority in need of pacification rather than being helpful, seemed to make their psychosis worse.

“Wasn’t a good place, just left there, given tablets and wasn’t anything else going on. I observed a lot of cruelty” (“Ann”)

The lack of emphasis upon relationships in mainstream psychiatry obviously meant attempts were not made to provide them. Further, when patients refer to report observing cruelty rather than experiencing it, I was left to wonder if the impact of the lack of healing relationships may

be an exacerbation of the characteristic social withdrawal and alienation from self. The medical focus upon symptoms, risk and compliance with drugs led to patients seeing doctors as agents of the NHS rather than healers or “as doctors rather than human beings”. Most patients reported persistent depersonalised interactions where their psychic fragility went unrecognised and an absence of shared humanity and understanding. Depersonalisation seems to beget depersonalisation, creating more psychic turbulence instead of helping patients heal. Patients spoke of the psychiatrists’ power to harm or destabilise through their inadequate attention to language and the need to contain anxiety and offer support through interpersonal interactions.

“I have a real problem if someone says they don’t believe me; the world goes all wobbly because then I can’t trust myself at all” (“Amy”)

Patients spoke of their greater vulnerability in psychosis and complained about how profoundly they were affected by the lack of attempts to understand them. When they felt “like shit” or disturbed through interactions with their doctors, it affected their ability to gain from the treatment and continue to recover. Patients felt diminished in developing stronger selves when their treatment lacked warmth, respect and recognition, focussing instead upon robotic tick-box protocols. All of the patients had gone outside mainstream psychiatry and into the Movement or psychotherapy to meet their relational needs. In an echo of the unconscious despair over the need for hope we came across earlier, we heard about efforts to build oneself being demolished by the negative influence of relationships with psychiatrists.

“I put myself in a vulnerable position and hope people deal respectfully and help me....but....I always feel very disappointed and let down when that doesn’t happen..yeah...very powerless because I am reliant on...them being active in understanding me” (“Fay”)

Patients referred to the destructive impact of the lack of positive active interest in them because such intentions helped them gain ontological security. They spoke of feeling belittled when little interest was shown in their humanity with the medical gaze focussed upon the objective phenomena of their symptoms. One spoke of being “indoctrinated with the mainstream

psychiatric view” in the early days of her diagnosis when she saw herself to have a biochemical defect, in line with the psychiatric view. During this phase only “symptom levels were of interest and in need of control, not my distress levels or trauma” because none of it was considered necessary. As they gained greater awareness through the Movement, the attempts to bring relational understandings into treatment fell on deaf ears. With the change in the narratives of their lives, patients struggled to hold on to their fragile new understandings through the implacable and steadfast resistance to the relational within psychiatry. Awareness of being alone, fearful and distressed in psychosis and the need for attention to those aspects was lacking and only encountered within the Movement.

4.6.2 Patients and the role of relationships

“Through being listened to, I realized that I wasn’t alone, you know. Listening...calms down the distress because somebody’s taken time, you know to listen to me” (“Nicola”)

Patients’ experience of early relationships with others and themselves had injured them but engagement with the Movement introduced them to their more positive possibilities. All of them found themselves at psychiatry’s door seeking relief from the distress of psychosis. Instead of gaining empathy, relief from distress or narratives that helped them make sense of their experiences, they experienced relationships which confused and distressed them even more. They railed against the irony of a system designed to treat them which misunderstood their fundamental needs and exacerbated problems by ‘othering’. They saw themselves as more whole when actively partaking with others in accepting and understanding their experiences and constructing a positive identity. Relationships within the Movement introduced them to an alternative view of psychosis as a painful life experience with an opportunity to grow. These relationships offered them recognition and empathy, allowing a path back into humanity instead of continued exclusion. Seeking alternatives to psychiatric orthodoxy became crucial for patients as they encountered the possibility of being affirmed and, to leave behind the experiences of cruelty and negation. Patients felt more secure in themselves and gained confidence in their search for hope and meaning when they were not ‘othered’ or condemned to the “loony bin”.

“Just because you hear voices does not mean that you’re mad, I have never forgotten that” (“Keats”)

Empathy and validation within the Movement allowed patients to separate their identity from experiences of hearing voices and allowed a move into recovery. Voices became a sign of human diversity, not irreparable damage or irredeemable madness. Acceptance led to less self-doubt and greater ability to pay attention to context and understand themselves. Several patients referred to the benefits of understanding psychosis in an atmosphere of respect, leading to a better relationship with self and others. Through relationships, patients came to see symptoms as symbols so that voices stood for internal dialogue which is meant to help in resolving problems. One learnt that acute and persistent voices about sexual immorality in others could be a sign of neurochemical imbalance **or** “a need to examine own self-esteem and morality”. The former kept him in the scientific medical paradigm whilst the latter helped him understand his “need to condemn others which was to do with my own fears”. Another example from many patients was the “encouragement to commit suicide” by denigratory voices which was understood as the need to examine self-worth, deriving from trauma and ill-treatment. Negative interactions within the NHS had led to such voices getting stronger through the internalisation of dismissive and denigrating encounters. All patients wanted psychiatry to recognise and engage with alternative ways to understand voices and hallucinations instead of sticking to a rigidly biomedical model. Through developing better relationships with their voices, several came to see them as disowned aspects of themselves, carrying important messages.

Another piece of evidence from amongst my sample of patients cements the critical role of relationships in the development and resolution of psychosis. One patient attributed the beginning of her psychosis at age 19 to the re-triggering of her trauma of being sent away to boarding school at the age of seven. She also linked her psychotic distress to her father’s experiences as a young soldier in the war, neither feeling able to speak of their loss and trauma. Further, she felt her family culture of keeping all distress private continued in psychiatry when her illness was dismissed simply as a biological reaction to stress. She felt strongly that had she been able to discuss and explore her emotions, her suffering and that of her family

could have been put to better use. Another treatment environment with adequate concern for the psychological and social and awareness of trans-generational trauma, may have turned her illness into an opportunity for her family to heal old wounds.

“I now know my psychosis was a protest against parents and institution....but I didn’t feel that the doctors were terribly interested in....hearing my story I guess so.....I would be very manic and shouty and sort of (laughter) angry and....maybe I was trying to tell them my story.....(laughter) but it wasn’t coming out properly” (“Bonnie”)

Psychosis disables, making it difficult for the patient to know their relationship needs and use them to work towards recovery so the healers need to be able to facilitate it. I found that most patients experienced psychiatry as equally disabled due to its lack of belief in salvation through human connection. The focus away from relationships or inner lives and towards biology resulted in losing the person behind the brain. Consequently, patients felt forced by the paradigm to fall in line and separate from their own ontology or ‘being’. Most patients contrasted the licence in exploring their process within the Movement with fearful reactions among professionals. Patients spoke of their ability to talk freely in the Movement about self-harm or hatred towards their children but the same conversations within psychiatry led to a loss of liberty or custody. Psychiatric practice was unable to offer the safe haven of relationships necessary to explore their experiences, without which they knew they would have remained stuck within the prison of psychosis. A few patients were engaged with psychiatry in accessing medication as well as psychotherapy and spoke of needing both to develop their relational capacities. A number mentioned their decisions to keep quiet about accessing the alternatives due to a feared disapproval from psychiatrists, which left them with the stress of managing themselves and their carers.

It also seemed that although patients were aware of the healing power of relationships, there was also some terror of the same and a reluctance to concede to it. Patients in the Movement could still be afraid of engaging with their own narrative or developing deeper relationships. Previous experience of inadequacy of relationships and their capacity to hurt seemed to have left their mark, making it difficult to use their healing capacity.

“Addiction to care and being understood....that frightens me to death, much better to be out in reality than living in some soap bubble” (“Amy”)

Patients chose to stay in the ‘real’ world where lack of care prevailed because that is what they were used to and felt frightened of opening up to relationships or getting addicted to feelings of care and understanding. They attributed their flight from relationships to experiencing many painful endings and a wish to avoid the distress of emotional abandonment. Closing oneself to all emotional connections seemed a safer option, suggesting a definite hopelessness about the possibility of healing bonds or a different future.

4.6.3 Relationships and psychiatrists

Although empathy was seen as an important bridge, only a few psychiatrists spoke of its necessity and the difficulties involved in the persistent and consistent engagement of both subjectivities. Some acknowledged difficulties in deep engagement with patients diagnosed with psychosis due to their own psychological defences but others appeared not to have considered such matters. Although none considered relationships to be unimportant, only those who had explored their own psyche seemed to have the nuanced understanding of factors impacting the ability to offer. Those who saw relationships as the more significant elements of the treatment felt marginalised within the profession. It is significant that the same psychiatrists who were more reconciled to personal and general human existential fragility were also more aware of the power of relationships. Those with less experience of exploring their own or patients’ psyches seemed less comfortable offering treatment outside of the mainstream of their training, focussing upon technology instead of relationships.

4.6.3.1 Relationships with patients

“I also liked the idea of spending more time with the patient....you know listening to the patient, learning a bit more about their life history...who they were as opposed to just quickly...assessing physical problems and moving them on.” (“Keith”)

It seems that “learning who they were” means a multitude of things depending upon one’s training and ontological view. For some, understanding the patients’ psychosis meant relating to them because the illness was a product of the psyche rather than meaningless symptoms. For others, psychiatry was more attractive than the rest of medicine precisely because it allowed for relationships but they were seen as an extra, not therapeutically purposeful or essential. For these psychiatrists, knowing the person did not change the mainly technological treatment whilst others considered ‘the relationship to be the treatment’. Modelling the taking of risks for therapeutic advancement contrasted with the cloak of detachment and objectivity as essential elements of psychiatry, for the two groups. Some spoke of the sufficiency of simpler models in using pharmacology to bring patients back from psychotic worlds whilst others dwelt upon the necessity of difficult psychological work in relational bridging with the patient. Most of my sample, apart from two, recognised that not all psychiatrists understood or felt able to do such emotional journeying because of the inadequacies of ordinary psychiatric training. Some recognised these shortcomings in training and took steps to develop alternative understandings and abilities, including the need to convince patients to come back into relationships and taking risks. Whilst both groups were aware of the attraction of relationships in their practice, their understanding of its role in treatment was vastly different.

“That’s the main part in therapy that...you take certain risks and the patient has to take a risk and that is a kind of joint adventure...that can lead to betterment, to healing and lovely experiences on both sides.” (“Hans”)

Getting closer to patients and their way of being in the world, in order to help them learn and experience more of life seemed to be the purpose of treatment for some. For others, the emotional connection and depths of psychosis remained of interest but unconnected to treatment and evoked some resistance. Some recognised that making oneself vulnerable in this way can lead to “worries about your own grip on reality slipping” but were confident of their ability to manage the risk whilst others spoke of their “need to detach from the process in myself and the patients to survive”. Such personal factors obviously affected psychiatrists’ ability and readiness to empathise with their patients, some seeing those as essential whilst others made

the same aspects incidental to the treatment. As I found earlier, some were more able than others to empathise directly with the patients.

“How do you understand the emotional depths that people get to? Literature helps so...it sounds pretentious but in thinking about the internal lives of patients, I think about a character in a Sartre novel, someone who put a knife through their own hand to convey despair.” (“Doug”)

Risking one's own grip on reality in order to help patients regain it feels like a radically different practice of medicine from relating to patients through a fictional character. Some seem prepared to risk their own sanity whilst others put limits on their empathy for fears of being profoundly affected. Personal awareness and philosophy of life, conscious or otherwise, seems to affect the approach psychiatrists take to their work. If one's personal philosophy is of self-contained beings where connections with others pose risks to one's essence, then psychiatrists focus upon diagnosis and explanation. The psychiatrist who spoke of the Sartre character, acknowledged his clinical emphasis was upon 'doing to' **not** 'being with'. For him, understanding the patient was useful but not essential to fixing them which was his *raison d'être*. For psychiatrists such as this, steeped in positivism, human process is mechanical and fixable, not about the power of fellowship or accepting limitations to the work. For others, the practice of psychiatry is intimately connected and predicated upon one's way of being in the world and needs to build upon the initial training received. The personal becomes professional as one's way of understanding oneself, life and others affects one's practice of psychiatry.

“If you come in...(to psychiatry)...wanting to distance rather than relating...then...you isolate & are isolated....due to personal & social processes and....for reasons of defence of your personality” (“Don”)

Psychiatrists may be coming into the profession for different reasons, to distance or use professional power to explain life whilst others want to relate and identify. There was a recognition that distancing from the emotional and psychological process is easier through the mainstream biological understanding of psychosis. The mainstream focus on technological

solutions to apparently structural issues and bias against relating wins out because the requisite emotional involvement is difficult. Some knew that bringing patients back into consensual reality cannot be done without developing therapeutic relationships and using them as instruments of psychic surgery.

“A bit of me thinks our operating theatre or where we do what we do is when we are in conversation with our patients...sometimes that is seen as oh, you are only talking...or you are doing something quite passive or you are just assessing but to me what you are actually doing there is....the real work” (“Dale”)

It has to be noted however that moves towards dialogue are fraught, so only “a bit” of this psychiatrist with decades of experience acknowledged the pull. One’s place within the profession as well as links with other psychiatrists are put at risk through listening to that part and focussing upon relationships with patients. Some psychiatrists made the hard choice of challenging traditional practice and gained personally and professionally by making the decision that relating with patients was the real work. Some referred to the satisfaction derived from their movement into liminal spaces, towards relational treatment from a predominantly biomedical view. One described her experience of greater personal efficacy and fulfillment because her newly acquired capacity to relate combined with her medical knowledge and helped her feel more integrated as a professional. She gained new meaning and fulfillment from her work through her training within a psychotherapy team, something she had never experienced before. Her account suggested that her training to date had related to the patients’ brains, with their context or her own self not playing a part in the work.

“now I feel that I can use myself as a healing agent because I didn’t appreciate that just you being there as a person listening...can make a lot of difference to them...It was always like, oh we have to put something in place...we have to refer to the crisis team...or he will have to come into hospital or must have diazepam or lorazepam.” (“Gita”)

Medical training seems to leave doctors dependent upon technology or a combination of technological and institutional interventions in the form of drugs or hospital wards. The idea of

countering the powerful effects of a neurochemical or structural fault, purely through relationship with patients had not existed in their training. Upon encountering alternative ideas, some were positively predisposed to overcoming any personal or professional resistance against emotional engagement. Others seemed to experience enormous barriers. It is impossible to comment upon the nuances of psychiatrists' relationships to bodies, brains and dependence upon personal factors through my limited research. It is obvious however that personal factors play a crucial role in the ability to pay the necessary attention to subjectivities and relationships. Whilst some are able to use their self and surmount personal defences against exposure and vulnerability, others resist exploring their own subjectivity and those of their patients and remain within the scientific paradigm.

4.6.3.2 Relationships with their selves

There is a demand within the Movement for the question, "how did you get here?" to be compulsorily asked of all patients to help them bring together their narrative, in line with the significance of the subjective. Psychosis is understood to distance patients from their own process and relationships, the aim of treatment being to reengage them with meaning and with others. Not all psychiatrists agreed with the idea however. I found some evidence of correlations between psychiatrists' attention to relationships with patients and their own motivations and subjectivity. The psychiatric process and the scientific attitude may be making it easier to interrogate just the body, sidelining empathy and subjectivity. Those who deemed it important to engage with emotions in patients had always been interested in their own motivations and psyche. Accordingly, many had sought personal psychotherapy and alternative training whilst others had been satisfied with simpler models of the mind, without attention to their own or other subjectivities.

"In terms of you know development and finding a way into adult life, I don't really know what led me there (into psychiatry)...I haven't really thought about it very much to be honest." ("Doug")

If psychiatrists are inattentive to their own process, deeming it irrelevant to self-understanding, they are unlikely to use clinical intuition to understand patient process. I found that for some

psychiatrists, use of self was a crucial therapeutic instrument whilst others remained ignorant of it. An interest in one's personal philosophy and the formation of one's self through relationships may be the defining difference between mainstream and fringe psychiatry. The fringe psychiatrists recognised links between their experiences and understandings of life and illness, most having used psychotherapy to understand themselves. The two from the mainstream made no such links between emotions and psychological development, even though one spoke of experiencing trauma symptoms from patient suicides and the other from early death of a parent. Neither of these two spoke of accessing psychotherapy whilst most others had. These psychiatrists seemed consistent in reproducing the attitudes they held towards themselves, with their patients.

"I couldn't say if there was any one particular case that I can remember...because I guess there were so many over the years." ("Keith")

A striking difference between the two groups lay in their accounts of meaningful encounters with patients and the ability of some to bring their patients' stories alive, with the two mainstream psychiatrists unable to do so. Other relationally oriented psychiatrists referred to case histories and used them to mark their professional learning, suggesting particular interactions with patients had profoundly affected their understanding. A chasm existed between those who understood reaching out as essentially human and others who believed in a narrower ontology. Whilst those inclined towards relationships could speak of lessons learnt through engaging with clinical need, a curious disengagement existed in others. Whilst one psychiatrist could remember the name of a patient from 35 years ago and the conversation he had, others could give no details of any meaningful or impactful clinical interaction. An ever-narrowing vocabulary of emotional distress and meaning may result in some psychiatrists treating chemical imbalance in the brain rather than relating to a person in pain. Whilst chemical imbalance in every patient may feel the same, some psychiatrists found that allowing themselves to be impacted by patients made it memorable and helpful in gaining greater understanding.

4.6.3.3 Relationships within the profession

“My generation of doctors were brought up on....a fear of unusual practice and risk aversion...fear of being adversely judged by their peers and the risks inherent in working with psychosis...together with the patients’ fragility and guardedness could make it difficult to develop therapeutic relationships.” (“Dale”)

Any doubt about relationships in psychosis treatment holding a strong charge were dispelled by evidence of virulent feelings within professional relationships, among both the mainstream and the fringes of psychiatry. Strong feelings were aroused on both sides, with those engaging in unusual practices such as the use of self expecting disapproval or worse whilst others felt their work paradigm was under attack. My data shows that relationships in psychosis are a battleground, both amongst psychiatrists and those between psychiatrists and patients. Psychiatrists were fearful of being seen negatively by their peers and their superiors and spoke of “performing for colleagues” rather than expressing own understanding. I gained insight into the pressure to comply with established practice and the sense of paranoia, threat and insecurity within the profession. It seems that psychiatrists struggle to offer the kind of therapeutic relationships they want to their patients because they do not feel safe and secure within the profession. Further evidence of this tendency to disallow debate and doubt others’ experience and understanding came from one of the mainstream psychiatrists within my sample. Upon being asked of his reaction to suggestions from eminent psychiatrists of schizophrenia being a human process, his reaction was

“I think its ridiculous actually, to be honest because based on anybody's experience of working with people with schizophrenia...you know to kind of suggest that's a good thing to be...seems crazy...to me” (“Keith”)

The notion that if psychotic process was human then it could not be simply pathological and distinct from a state of health enraged him. He went to claim that people holding such opinions could not really have worked with schizophrenia because then they would not be able to hold such views. The tendency to ridicule and misunderstand eminent psychiatrists such as Sullivan

(1962) whose idea of *Schizophrenia as a human process*, was being referred to, suggests the issue provokes powerful emotions. It implied an emotional need for a narrow definition of psychiatric practice and the demands for homogeneity and clear distinctions between human process and definite illness. Another graphic example of divisions came through a psychiatrist speaking about the conflict between herself and a senior colleague. She felt that her “questioning of whether doctors should be involved in psychiatry” posed a threat “for people with personal and professional investment in that identity”. Her self-identity as a philosopher and a social scientist trained in medicine led to her mainstream colleague who was also her manager, experiencing her ways of working to be “fundamentally incompatible”. This conflict had left her “feeling threatened, demoralised and anxious.” Such practitioners on the fringes of the profession saw themselves as critical of but not anti-psychiatry and wanted the profession to expand its horizons, seeing itself and the patients holistically. Statements and experiences such as the above provide evidence of the paranoia and insecurity that exist. Whilst the patients need to feel safe enough to come back into relationships, divisions and insecurity within the profession may make it impossible to offer the requisite secure base.

“A lot of the putting down of others....is a defensive reaction really against own limitations or the feeling of being a less desirable race...within medicine.” (“John”)

A reason for the divisions and insecurity and intransigence against challenges to the paradigm may be the greater scientific and technological credibility of other medical specialities. The wider technological base of disciplines such as cardiology, compared with the social and humanistic aspects of psychiatry creates feelings of inadequacy and inferiority in some professionals. Some of my participants were frustrated with the social aspects of the profession and with their lack of awareness of this hierarchy within medicine when they chose their speciality. There was evidence for the stigma and lower status of psychiatric work being defended against by disrespecting the colleagues and patients who challenge. Both the hostility and the frustration may be being passed down the food-chain, with alternative psychiatrists feeling insecure of their place within the profession and patients’ experiencing degrading treatment. If our ability to manage life’s demands is determined by our emotional states, it is not

a huge leap to imagine that individual psychiatrists' ability to self-soothe and remain available to their patients is affected by the social regard they receive.

4.7 Systemic hazards to relationships

In this section, I present specific evidence of systemic attitudes towards relationships but these findings must not be considered alone. They need to be seen in conjunction with the significant evidence already presented about the technological bias in interventions as well as participants' feelings of cruelty and abuse, all of which suggest a non-relational attitude in treatment.

Table 6: Illustration of the concept of Supportive systems

Concept: Supportive systems	Participant quotes	Researcher interpretation
Patients	<p>I would like...to feel...when they ask me a question...about what I was hearing that they are not just listening for the tickboxes, that they are actually listening to what I experience of it "Fay"</p> <p>Wasn't a good place, just left there, given tablets and wasn't anything else going on. I observed a lot of cruelty "Ann"</p>	The patients felt there was no place for the personal or the subjective in the psychiatric system, it all felt depersonalised and objectified.
Psychiatrists	<p>Our approach to psychiatry...a natural extension of our tendency to build systems without flexibility or feedback from reality. We are all made ill and paranoid by our disconnected and fragmented lives because we are not aware of our fundamental needs. "Hans"</p>	The psychiatric system produces an ontological split, forcing us to live in a world far from the real one.

4.7.1 Patients' accounts

"A lot of the professionals I have met are dissatisfied with the system...because they can't interact in the way that they want to... you know there are humans in the system...it's just that they often get swallowed up." ("Fay")

Patients who were active within the Movement had a considerable involvement with and understanding of psychiatric practice. They spoke of the impact of the institutionalised

Findings

devaluation of emotions and connections amongst psychiatrists who they understood to feel unable to relate in the way that they wanted to. In getting swallowed up by the system, the doctors had lost touch with the fullness of their own humanity which in turn made it difficult for them to relate to the patients. Extensive bureaucratic demands and emphasis upon short-term interventions and division of labour meant that the kind of attention needed by patients was often not available. Through their activism, patients had come to know that their life existed in their stories, not diagnoses and they wanted their doctors to adopt the same attitude and see beyond the diagnoses. They felt consistently defeated by the emphasis upon categorising and medication and complained of its depersonalising effect. Patients ascribed their experience of cruelty and a lack of positive social interaction on the ward to the institutionalisation of a biomedical narrative, within which relational aspects were insignificant.

All the patients fought against the systemic tendency to simplify psychosis and the lack of acknowledgement of the complex treatment required. Patients wanted to explore their world-view and the felt threat to their ontological security in their treatment and not be drugged into numbness. Additionally, patients demanded that their distress about increasing levels of mental fog or physical debility due to medication side-effects be taken into account in evaluating their treatment. Patients felt disempowered by the institutionalised bias against relationships, in the form of a division between 'us' and 'them'. Instead of working together, patients experienced a split where the presumption was of the psychiatrists being on the side of health and the patients in the wrong. Existential aloneness and a shaky grasp on reality due to psychosis, combined with the systemic bias against relationships left patients on the defensive, and further from the sense of safety necessary for healing. Huge concerns were expressed about the power vested in psychiatrists with some comparing it to "an abusive relationship", with the abuser "legally entitled to be judge, jury and executioner". The biggest fears related to the power held by the system to withdraw the possibility of having families and questioning their "right to breed". The wish for a dialogue and healing was resisted through the institutional assertion of power, with relationships used to harm rather than help, reminiscent of patients' early experiences.

In line with literature, most patients recognized that their psychosis had developed as a result of avoidance of psychological and emotional work on their part. They recognised their need for

help with integration through explorations within safe relationships and bemoaned the dismissal of that need within psychiatric practice.

“I would tell him some very very bizarre, obscure things but he knew I just wanted that space and he did not say, I think you should go and take your Sulpiride and go to bed” (“Keats”)

Patients contrasted their experiences in psychiatry to those within the Movement where they discovered a new coherent and helpful narrative, through being attended to holistically. They talked about the value of learning novel strategies to manage life through relationships, activism and psychotherapy by putting themselves together in a new way. The patients felt that their newer narratives reflected the complexity of human life better than the split narratives previously imposed upon them. They found a different perspective upon psychiatry by recognising that it lacked coherent answers to their questions about attention to context and psychology in psychosis. They questioned the mainstream belief in the arrival of a fully formed schizophrenic adult at the moment of the biological accident and, its neglect of how context and relationship experiences contribute to the development of the senses of self and others.

4.7.2 Systemic hazards to relationships: Psychiatrist accounts

“Bringing people in a psychotic stupor which is very much those situations where people feel totally alone...I would say an acute ward in those circumstances is the most horrible environment you can be in...over-agitated patients...are held down where they are physically constrained...they are...oooooooooooo...so a lot of our treatment methods on acute wards are totally counter-productive and harming patients.” (“Hans”)

Both mainstream and fringe psychiatrists referred to the organisation of psychiatric treatment in the NHS as untherapeutic. They felt powerless against the dominance of mass production principles in treatment, with the main objective of controlling costs. As in the above statement, the terrors and fears of annihilation in psychosis were ignored, with those suffering existential aloneness exposed to threatening and harmful environments instead of safe and growthful

relationships. Accordingly, some compared psychiatric wards to “holding pens rather than therapeutic environments” where treatment was experienced as assault. The resulting conscious and unconscious conflicts within the profession and between patients and psychiatrists was seen to lead to a fraught, adversarial treatment atmosphere, not conducive to the development of the thinking function, necessary in treatment.

The individual resistances and fears against the relational aspects that I highlighted above were augmented by the systemic tendency to prioritise economic factors above holism. Those fears and prejudices manifest in the design of services so psychiatrists lamented the ongoing divisions keeping the psychological and the social split from the biological in psychosis. Some of them recognised that, the fear of empathising with patients weathering the storms of psychosis, could result in their avoiding any signs of human vulnerability and fragility, in self and others. They acknowledged the damage to patients and psychiatrists alike, with the feelings of anxiety and fear removing the search for connections and flexibility in treatment systems. Recognition of these problems made some reassess their professional training and found it lacking. They wanted training to focus upon the links between their personal and professional identities and help them integrate, with a move away from monocultural biological psychiatry as an essential part of that. I cited evidence earlier of psychiatrists feeling more integrated and skilled through exposure to other therapeutic languages and contextualised phenomena. They learnt that emotional connections with the patients and their stories and their own context helped them to better understand the clinical picture of psychosis. Ultimately, they were disappointed to recognise that their training had not exposed them to the wider picture and felt the issue was too important to be left to chance or individual interests.

“They think its 3 different strands...of medication, CBT and psychodynamics...so oh...I like medication because it works straightaway...I will go for that...some say...ooooohhh psychodynamic...that looks nice to understand the meaning of it, I will go for that but nobody tells that all the three are needed in one patient” (“Raj”)

Psychiatrists complained about the splits imposed upon their individual understandings and psychiatric training due to institutionalised ontological splits within the system. The most

experienced psychiatrists knew that the most critical aspect of working with psychosis was to help integrate the patient but that the basic training did not help them to even recognise, let alone meet that need. Instead, they learnt to split their patients, believing that each strand of treatment whether it was medication, CBT or psychodynamics would all achieve the same result. Although it would be inaccurate to say that understanding patients was unimportant in general psychiatric training, my sample suggested that it lacked depth. A holistic understanding of the bio-psycho-social aspects does not seem to be an integral part of medical training and, according to some its significance is arrived at by chance.

“These groups are a resource to support the team and...help us clinically but they are not used with the usual rationalisations of time...but the real reasons are our defences against exposure and vulnerability. As a senior medic, I should attend to show commitment and leadership but I don’t.” (“Len”)

Systemic difficulties with relationships left psychiatrists confident in fixing technical problems but floundering with complex emotions in self and others. My final evidence relates to the systemic deficiency in helping psychiatrists manage the difficult emotions evoked in the course of their work. Facilitated process groups reflect a psychological approach where professionals learn to pay attention to the emotional impact of the work and understand the functioning of psychological defences in self and others. The aim was for the psychiatrists to recognise their emotional reactions so they could serve patients uncontaminated by their own difficulties. Most psychiatrists reported that such groups were abandoned due to resistance towards the vulnerabilities presented by emotions and relationships. Only those senior psychiatrists at ease with human frailty seemed to understand the rationale for such groups but even they felt helpless against the systemic dynamic. It appeared to be easier to ignore social and psychological realities allowing such approaches which tend to emotional needs in psychiatrists to wither away and, with them, any chances of meeting patient needs. The ultimate irony may consist in this denial of relational needs amongst the healers, another version of the original problem that had produced the psychosis in the patients. Systemic pressures towards a narrow perspective on life may be discouraging the very human search for meaning, hope and relationships.

Chapter 5.

Discussion**5.1 The need for synthesis**

I set out to explore and understand the experience of psychosis treatment in the NHS amongst patients and psychiatrists. My data suggests that the conflict in the treatment results from an ontological clash; the psychiatric system and treatment does not reflect the real worlds lived in by the patients or the psychiatrists. Current systems of training and treatment do not support the human needs for meaning, hope and relationships. This ontological clash and the abyss between the inhabited and the imagined worlds need to be addressed so that the doctors and the patients share the same world.

The conflict manifests in patients fearing their treatment and resenting their healers' misunderstanding of the psychotic process and their needs. This missing essence of the treatment became clear to patients when they encountered alternative paradigms within the Movement. Similar conflicts surfaced amongst psychiatrists when those who had ventured into other disciplines of psychotherapy and philosophy questioned the adequacy of their biomedical training and their psychiatric identity. For psychiatrists, the conflicts and resulting harm result from inadequate theorisation and understanding of the human subject, psychosis and psychiatry. Instead of splitting life into its social, biological, economic, psychological aspects, a synthesis is required because the problems stem from a lack of understanding of 'the human'. The conflicts I found, impact both sides adversely, with patients unable to recover from their distress and the psychiatrists left professionally unfulfilled and unintegrated. The dominant analytic mode in psychosis treatment leads to a battle of wills, the need for a worthwhile life and self-determination pitted against the systemic need to control costs. This quote from one of the patients succinctly answers my research question by highlighting the reasons for conflict, raising questions of how to help sustain worthwhile lives.

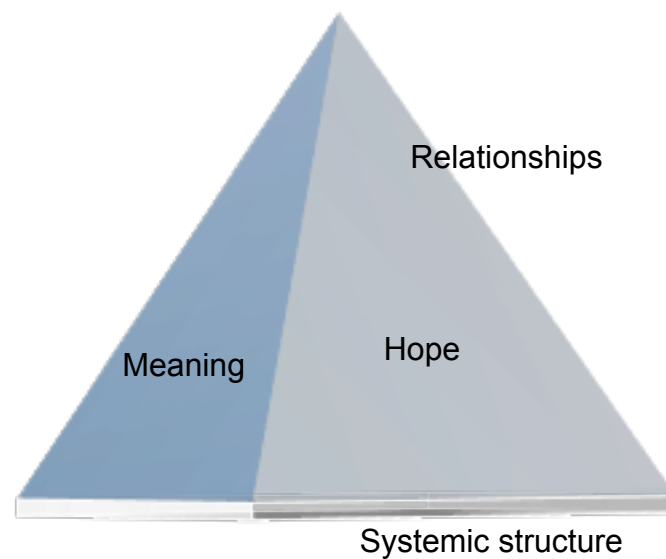
"We fight due to the fact of different agendas, he wants to keep me out of hospital whereas I want to keep my medication down to a minimum...in order to have a life up to a point" ("Amy")

5.1.1 If the house of psychiatry is to stand....

Patients and psychiatrists emphasise meaning because experiences of psychosis were deeply connected to personal trauma and recognising this was necessary for patients. Insisting that psychosis was a meaningless biological accident was the first major harm, taking patients away from health and psychiatrists from understanding. Secondly, both patients and psychiatrists needed hope, without which it was impossible to negotiate the unimaginable psychic storms of psychosis. Lack of hope in the medical paradigm led to long, fearful periods in wilderness for both groups because they were dependent upon inadequate technological medicine. Thirdly, the patients and most psychiatrists in my sample emphasised affirming relationships with self and others, expressing surprise at the ignorance of that need. Relationships are the essential conduit through which meaning and hope are carried into the patients' psyche and sustain both sides. The lack of a path back to health in the medical paradigm was contrasted with the Movement where patients found meaning, hope and relationships to sustain themselves. The final finding was that these difficulties at individual levels are perpetuated by the systemic disregard of meaning, hope and relationships in mainstream psychiatric training and treatment.

The conflict within psychosis treatment that prompted my interest in this study arises when meaning, hope and relationship are ignored. Those aspects of human ontology are likely to be significant in all health settings but patients with psychosis are likely to suffer greater ontological insecurity than most patients. I propose a diagrammatic representation of a notional house of psychiatry, as a three-sided pyramid. Within this structure, the three walls of meaning, hope and relationships are kept in place by supportive systems, symbolised by the ground holding them up. Supportive systems are therefore just as important as the walls of meaning, hope and relationship in optimal treatment because they are needed by all involved, psychiatrists and patients. If these factors continue to be ignored, the house of psychiatry is likely to collapse under the resultant conflict and tension.

Figure 1. The notional house of psychiatry based upon findings



5.2 The need for meaning

5.2.1 Patients and meaning

All the patients in my sample were on a quest for meaning because they knew their symptoms meant more than disrupted neurotransmission. Some felt that unresolved childhood abuse had led to denigratory voices whilst others were convinced of their self-expression through art being significant and wanted help in exploring it. The attitudes they encountered in treatment however, privileged only the biological meaning of dysfunction and disregarded the seeking of meaning in their life experiences. It defies belief that no meaning was ascribed to the whole life experience of the patient born out of the violence of rape who faced abuse and hatred at hands of her mother but a single cocaine binge in her 30s was deemed instrumental in her psychosis. Naturally, conflicts ensued with clear battle lines between distinct ontologies of life, as a quest or simply doing one's laps in the pool without bumping into others (Frattaroli 2001). Disregarding the quest perspective meant emphasis was placed upon material aspects and use of drugs to treat the tangible problem (ibid.). The quest paradigm sees psychosis as a call for awakening to one's purpose or meaning and, is not content to see it simply as an illness (Grof 2011).

This conflict is akin to the split between the biomedical and the psychodynamic minds of psychiatry, which Luhrmann (2001) found to be based upon different conceptualisations of life.

She outlined the concepts of essential and inessential suffering where the latter does not change individuals but the former defined our 'self' through clarifying our wants, fears and personhood, as in the quest perspective. Her patients and mine, felt angry about the dismissal of their reality by a simplistic biomedical mind of the profession where psychosis was akin to diabetes, a biological accident or inessential suffering requiring management. Drawing connections between their lives and psychotic experiences, my patients saw the illness as essential suffering which required understanding and integration. Whilst psychiatry denies the essentiality of mental illness, Luhrmann's patients (2001; p. 272) discovered "useful lessons... through explorations outside of mainstream psychiatry.... understand(ing) pain as part of life... as a spiritual lesson". Freud (1914) said something similar about the need for the patient to "find courage to direct attention to his illness.... as a piece of his personality, out of which things of value for future have to be devised". A succinct version of above theses would be, 'We are not born whole but need to suffer the vicissitudes of life to become who we are'.

Patients complained about the imposed disconnection between their history and illness as if experience was meaningless and the monitoring of their symptoms "as if they were independent of distress and feelings". Having examined issues from other perspectives and gained greater self-understanding through the Movement, they were puzzled at the decontextualisation demanded in mainstream psychiatry. They felt angry and upset at the discouragement and barriers placed in their path towards accessing psychotherapy or other alternatives. The patients' 'self' is what goes on the quest and seeks meaning, is the subject of the psychodynamic mind and also the concept biomedical psychiatry is criticised for lacking (Burgess Watson 1996; Kecmanovic 2011). These writers suggest that the biomedical mind of psychiatry does not see any lack in its treatment, because it does not even recognise the concept producing the conflict. I believe that these very different languages and attitudes used by the two minds of psychiatry have created a conflict reminiscent of Babel. When patients felt their search for meaning and coherent sense of self was dismissed, their fear of annihilation was triggered, leading to the conflict in my sample and literature.

5.2.2 Psychiatrists and meaning

Whilst some psychiatrists complained about the simplification used in understanding psychosis without attention to the meaning in our lives, others saw that as an instance of the human difficulty in reconciling to being 'just bags of chemicals'. That argument is akin to the critique by Parnas (2014) where psychiatry is accused of banishing psyche from its purview, by privileging symptoms over depth and structure. In the contemporary neuro-psychiatric world, issues of soul, wonder and mystery have been banished in favour of cold hard science, whilst modern physics has moved in the opposite direction, as the following quote shows (Paul Davies, July 1983, Sunday Telegraph)

To study the new physics is to embark on a journey of wonderment and paradox, in which subject and object, mind and matter, force and field become intertwined...We are moving towards an understanding in which matter, force, order and creation are unified into a single descriptive scheme. To me the laws of the universe, from quarks to quasars dovetail together so felicitously that the impression that there is something behind it all is overwhelming...

The contrast between poetics from pure scientists of an unmeasurable hidden force field making its presence known and, psychiatric insistence on tangibility and objectivity is striking. Physicists seem to be looking for meanings in universal laws whilst mainstream psychiatrists jettison context and meaning for "simple biological dysfunction" (Sharfstein 2005). Patients wanted attention to and engagement with their individual psychic storms (Jackson 1994), instead of having them rationalised away. Paying attention to human complexity, particularly of the kind from phenomenological literature requires health to be seen as more than our material self. Perhaps psychiatry needs a challenge from within a scientific perspective and the physicist Bohm (Rinpoche 1992) comes to our aid. His thesis is that reality is supported by three inter-convertible pillars of matter, energy and meaning, with everything being a part of the undivided whole. His implicate order of the universe posits the need for different investigatory tools dependent upon the questions being asked, rather than using the same tools regardless. He distinguished between coarse and subtler levels of reality by showing how matter turns into mind as it gets more subtle or vice versa.

If you read a printed page, which is a form, the meaning gives rise to an energy from which you act. Therefore we could say that the distinction of materialism and idealism is eroded, it gradually dissolves...Pure idealism would reduce matter to an aspect of mind. Pure materialism would reduce mind to an aspect of matter, and of course that's what we see in a great deal of modern science. My view does not attempt to reduce one to the other any more than one would attempt to reduce form to content...Every content is a form and every form is at the same time a content."

In his thinking, psychiatry would be guilty of firstly reducing the mind to an aspect of the brain and then proceeding to ignore it. This tendency is questioned by a psychiatrist Brendel (2006) who asks, why neuroscience rather than life as it is lived qualifies as foundational for psychiatry? Bolton & Hill (1996; p. 274) believe "explanations in terms of meaning are to be regarded as just as causal and just as much a part of science, as chemical and physical lesions". My sample of psychiatrists, similarly asked questions about the denial of meaning in symptoms, helping us understand some of the conflict within the profession.

Developments in the field of Epigenetics (Carey 2011) further highlight the complexity inherent within psychiatry, as we learn that experience creates changes at genetic levels. Changes in gene expression can change neuronal connections which ultimately contribute to the biological basis of individuality as well as initiating and maintaining the "abnormalities of behavior ... induced by social contingencies" (Kandel 1998, p. 460). In light of these facts, it is difficult to see how psychiatrists can continue to target only the biological aspects, without understanding the impact of experiences upon the person. As the nature-nurture dichotomy becomes invalid, simplification of treatment to a 'one word diagnosis and single medication' or claims that 'addictions maybe social but not schizophrenia' become suspect. Kendler (2005, p. 433) prominent American philosopher, neuroscientist and psychiatrist critiques psychiatry's "naïve" separation of the biological, psychological and cultural factors. He asks two pivotal questions: "how do mind and brain interrelate? And, how can [psychiatry] integrate the multiple explanatory perspectives of psychiatric illness?". He criticises the discipline for not addressing these fundamental questions and failing in understanding its subject matter. Hard reductive models

strive for clear 'one-to-one' relationships between basic neuronal processes and emotional or behavioural processes but such simple relationships just do not apply in psychiatric illnesses (ibid.). Our systemic nature means that psychopathology does not exist and cannot be understood concretely at any single level so sadness or paranoia can certainly be represented at neuronal levels but may not be the most efficient level to observe or understand them (Gabbard 1992; Robbins 1993). No single science has a monopoly on the comprehension or treatment of psychiatric distress (ibid). My findings and these authors re-assert the need for psychiatry to adopt pluralist perspectives and address its major epistemological and ontological inconsistencies.

5.3 The need for hope

5.3.1 Patients and hope

Patients referred to the devastating impact of the diagnosis of psychosis upon their sense of hope for the future. Their fears of annihilation increased in intensity upon getting a overwhelmingly negative prognosis, as they were told to give up on all dreams of family or careers. Their sense of hopelessness was added to by their confusion and fears about psychosis and the cruelty of their treatment, which left them despairing of any relief from suffering. The loss of hope and the need for it from the treatment is graphically highlighted with a simultaneous record of a psychiatric encounter (O'Hagan 1996: p. 46). The death of hope in this patient seems imminent as she reconciles to her expectations of the lack of a listener and the doctor duly obliges. There is a poignancy in the impact of the failure to connect with the patient and draw her out, as we contrast her words with those from the doctor:

Today I want to die. Everything was hurting. My body was screaming. I saw the doctor. I said nothing. Now I feel terrible. Nothing seems good and nothing seems possible.

I am stuck in this twilight mood

Where I go down

Like the setting sun

Into a lonely black hole

Where there is room only for one.

Flat, lacking motivation, sleep and appetite good. Discussed aetiology. Cont LiCarb 250 mg qd.
Levels next time

Although everything was hurting and she wished to die, she saw the doctor in hope but he failed even to notice her existential estrangement, leaving her feeling worse. Her evocation of her internal state says much about her need for hope through relationships but the doctor's words devalued precisely those needs, as my participants repeatedly observed. The psychiatrist attributes the lack of motivation to the aetiology of chemical imbalance, presumably to be addressed by the lithium.

Psychosis has been described as unimaginable psychic storms accompanied by fears of psychic annihilation (Jackson 1994). Confirmed links exist between unbearable early trauma and development of psychosis (Romme et al. 2009; Moskowitz et al. 2008; Read et al. 2005). Dissociative detachment in psychosis 'undermines the individual's grounding in the outer world, thereby hampering reality-testing and rendering the individual with post-traumatic symptoms vulnerable to the nightmarish inner world' (Moskowitz et al. 2008, p. 332). Only hope of a meaningful future keeps people alive in unbearable suffering (Frankl 1992), something that seems true for all patients. Patients in my sample referred to a fragile hold on their reality and the need to look for hope or the flame of life because usually the isolation of psychosis blows it out (Becker 1973). Whilst most people keep hope alive in the face of anxiety and consciousness of mortality through an illusion of meaning in their lives and enduring value through the cultural matrix, psychotics cannot (ibid.). This leaves patients unprotected and missing out on pre-reflective attunement, something which usually provides a sense of being at home in one's body and the world (ibid.). Schwartz (2013), a psychotherapist using Becker's thesis in his work with psychosis found that hope of integrating the body and the self is crucial in treatment. Attention to experience is necessary to rebuild connections between the body, self and culture but the mending of these broken bridges of hope did not happen in psychiatric treatment for any of my patients. These findings are in line with phenomenological psychiatrists (Frattaroli 2001; Parnas 2013) and the contextual psychologists (Stolorow & Atwood 2014).

Fury at and conflict with the psychiatrists arose from their consistent and persistent failure to deliver hope, as my patients were asked to “keep taking the tablets”. A constant undermining of their self-perception through cruelty and lack of attention to the need for hope led patients to look for it within the Movement (Romme et al. 2009; Russo and Sweeney 2016; Millett 1993; Grobe 1995; Luhrmann 2001). These writings emphasise political involvement in the movement to gain validation and a sense of place in society after the loss of agency in the biological paradigm. Psychiatric inattention to the concept of ‘self’ means that security in our ‘being’ is not considered when it is in fact crucial (ibid.). The patients in my sample similarly found their selves through the Movement.

5.3.2 Psychiatrists and hope

Most psychiatrists in my sample connected patients’ experiences of early trauma and difficult relationships to psychosis, questioning the mainstream focus upon the brain rather than the person. The psychodynamic mind of psychiatry sees human individuality flourishing through recognition from others, with the corollary of non-recognition leading to shrinkage (Luhrmann 2001). Some psychiatrists mock the fact that self-disorders i.e. difficulties with one’s sense of self, are not diagnostically crucial features in psychosis (Parnas 2011). Others suggest psychosis is simplified to chemical/structural problems because of the emotional difficulties in empathising with the patients’ fragile inner world (Stanghellini 2004). This problem with empathy will necessarily impact upon the need to carry hope for patients because psychiatrists would have to recognise patients’ inability to carry hope for themselves. Perhaps the burden of the work becomes easier by adopting a technical model where there is no need for feelings and relationships with patients. Psychiatrists in my sample recognised that this focus on technology means nothing human enters the discourse, patients with psychosis seen in the same way as those with diabetes, with only the symptoms engaged with. The clinical core of psychosis as a disorder of the self goes unrecognised and the personal difficulties and fears in the work become an aside, rather than fundamental to psychosis (Parnas 2011).

The shrinkage of personhood in psychiatric treatment of psychosis was recognised by Barrett (1996), an anthropologist and practicing psychiatrist, who proposed that such patients got a liminal status. He found these patients were socially defined as a person in transition, not quite

a person but not dead either (ibid.). He described the dynamic processes leading to changes in patients' identity from a person with "acute psychosis" to a "chronic schizophrenic", where they morph from a person with a past to one without hope or a future. He points to their indeterminate and open-ended suspension in the liminal phase because, once a diagnosis of schizophrenia is made no certificate of mental health is ever issued. Patients in his study moved from acute wards at the front of hospital to chronic ones at the back, as the neo-Kraepelinian prophecy of hopelessness gradually manifested. Confirmation of personhood going into limbo post-diagnosis, came from some of my psychiatrists' difficulty in connecting to patients' stories whilst others expressed frustration with the passive acceptance of emotional and existential impoverishment among patients. The lack of a return of meaning and personhood in psychosis, suggesting a 'death in life' in Barrett, thus ring true to the experience of my sample. The implication of Barrett's work is a uni-directional arrow of time, demanding abandonment of all hope in this destructive illness. The significance placed upon hope and the distress and conflict in its absence in my sample, supports such implications.

Psychiatrists in my sample drew attention to the hopelessness within, through the professions' use of the same materialist models and arguments for the past century. Biomedical psychiatry follows the honourable traditions of materialism by downplaying subjectivity. That is the most likely reason for the low morale and hopelessness in surveys by Katschnig (2010) and Stuart et al. (2015), as the shortcomings of psychiatric paradigm are acknowledged. The RDoC project at NIMH, a redesign of psychiatric nosology is symbolic of that situation (Cuthbert 2014; Morgan 2015). Appeals for attention to subjectivities using Bohr's Complementarity theory would be too much a part of the quantum paradigm, which may but hasn't replaced the old science yet. Science has failed to develop technology to map lesions in personhood or psychic structures but continues to question the reality of the self (Frattaroli 2001; Zachar & Kendler 2007; Dewhurst & Bruges Watson 1996). Materialist psychiatrists are losing hope in their old methods and not finding it in anything new because they are not exposed to the language of intersubjectivity. For those who believe in the power of relationships, something significant is lost when scientific psychiatry insists "the personhood of neither the scientist nor the patient is relevant to the efficacy of psychiatric treatment" (Luhmann 2001; p. 177). Conflict and distress exists within psychiatry around its loss of hope and ability to offer it to patients, provoking calls

to address the “limited capacity for critical neuropsychiatric thinking whose idea of psychiatric biology is equated with the relatively narrow field of psychopharmacology” (Lacy & Hughes 2006).

I fear this inflexibility of thought and approach towards psychosis may derive from something akin to the process leading to the hopelessness of psychosis. Adopting an abstracted, neutral and contemplative attitude when empathic engagement is needed, means that the psychopathology of psychosis encounters another pathology, that of too much reason (Honneth 2008). I follow Morgan (2010) in his adaptation of Honneth’s concept of reification, to highlight examples where psychiatry reduces complex issues of the patients’ loss of footing or fear of annihilation to simple chemical imbalances. Morgan (2010) suggests a parallel between this reification in psychosis treatment and the hyper-reflexivity in psychosis (Sass 1992) where the lack of contact between the patients’ body, emotions and rationality means everything is deadened, taken out of the flow of life and subjected to over-contemplation. Psychiatrists engage in reification, deadening their interactions with patients, due to the human difficulty with uncertainty (Luhmann 2001; Frances 2010). Although the DSM preliminary text advises that the “disorders” do not “exist in nature” because mental disorders are not discrete entities with absolute boundaries (ibid.). Human nature ignores such advice in desperately warding off the hopelessness in modern psychiatry and psychosis treatment and makes symptoms of schizophrenia into absolute markers rather than co-existing features of distress. In attempting to suggest it has carved nature at its joints and identified a real illness, psychiatry faces more problems through making it difficult to tell schizophrenia apart from bipolar illness, severe depression or anxiety (Morgan 2010). We came across critiques from my sample about the technological emphasis removing all awareness of patient needs from the clinical picture. Reification, a sociological, phenomenological and philosophical concept, becomes a way of imposing structure and understanding, but loses all context. Whether done by an individual patient in the grip of psychosis or a profession ill-at-ease with human complexity, the result is misunderstanding and distress with the patients losing hope of healing and the psychiatrists of vocational fulfilment.

5.4 The need for relationships

5.4.1 Patients and relationships

Patients complained about the dismissal of their reality and the lack of attention in treatment to their experiences of psychosis, something they related to the quality of their relationships. They emphasised the impact of attitudes, thoughts and feelings of others in exploring and valuing their subjectivity and engagement, gaining much support and self-understanding through the relational matrix of the Movement. In this regard, they experienced a total neglect of inquiry in mainstream psychiatry through not being asked “how have you got here?”. Discouraged from reconnecting with own bodily and psychological experiences, they experienced the absence of an overarching ontology. In an exploration of his own recovery from schizophrenia, Coleman (2004) described how his ten years in treatment turned him from “a lonely and unhappy person into a perfect schizophrenic”. Whilst isolated and depressed with treatment focussing upon maintenance through medication in treatment, his recovery took off when a fellow voice hearer reassured him “the voices were real” and meaningful. That sentence became his *“compass for... the direction I needed to travel, underpinning my belief in the recovery process”* (p. 12). The contrast in their experience of relationships within psychiatry and the Movement meant that patients understood themselves within the Movement whilst ironically, psychiatry became another hurdle in their quest. Rich accounts of becoming a person through gradual awareness of self-consciousness as a unity with multiple selves in health and psychosis, exist (Hegel 1978; Berthold-Bond 1995; Sartre 1943; Lysaker & Lysaker 2005; Stanghellini 2004; Sass et. al. 2013). An inner dialogue, the signature of human condition, (Hegel 1978) is a fundamental phenomenon of our self-consciousness and the way we recognise our internal divisions and yearning for unity or self-becoming. Phenomenologists have shown psychosis can be seen as the failure of such a process, a lack of integration of body, psyche and soul (Frattaroli 2001; Parnas 2011). Patients in my sample and other studies lamented the lack of safety in early relationships and its contribution to their psychic fragmentation (Romme et al. 2009; Strand & Tidefors 2012). Neglect of such experiences within psychiatry were contrasted with the support and attention paid to their inner process within the Movement, something that my patients saw as enabling in developing deeper relationships with self and others.

Crucial knowledge about humans being embedded within a mutually impacting flow of subjectivities (Stolorow & Atwood 1992) is sidelined in psychiatry. Developmental psychology (Stern 2005; Trevarthen 2005) has revolutionised our understanding so we know that repeated mutual and supportive interactions with carers form a cradle within which the human mind develops. Hobson (2004) explored the development of the self and thought in children, building on Trevarthen's work and found nurturing on-going emotional interaction between the carer and baby to be essential. Mutual, emotional connections with carers allow babies to recognise the existence of other minds, such on-going supportive environment facilitating the development of their own mind and their ability to share perspectives. Winnicott's spontaneous gesture (1960) is a similar integrating function to help the baby's embodied self come into 'being' through repeated meetings with the (m)other. This provision of the integrating function through the (m)other's holding keeps the existential fire in the belly burning. Without an injection of this fuel, the Winnicottian baby never quite comes to life so that in psychosis, the body remains deanimated and the spirit disembodied (Stanghellini 2004). Bion wrote about the baby's use of the mother as the container (1962) in order to turn natural existential dread into manageable thoughts. I also read the phenomenological contextualists (Stolorow, Brandchaft & Atwood 1987; Stolorow, Atwood & Orange 2001) and the idea of dialogic/relational self (Sampson 1993) as emphasising the fundamental role of the other in our coming into being. The individual's world of inner experience is embedded within the inner and outer worlds of significant others in a flow of reciprocal mutual influence. That reciprocity makes the dichotomy between intrapsychic and interpersonal realms obsolete as the outer becomes difficult to distinguish from the inner (Stolorow & Atwood 1992). In all these theories, our self comes into existence gradually and maintains itself through recognition within our relationships, making them ontologically essential. Social constructionists recognize our personalities and all mental distress including psychosis, as an outgrowth of such a process with individual, socio-cultural and biological aspects (Stolorow & Atwood 1992; Sampson 1993). My patients referred to their failed search for such relationships and understanding within their NHS treatment and pleasure at experiencing it within the Movement.

As psychological beings, capable others experienced in negotiating their 'selves' in the world are needed to grant us our licence to selfhood. Tragedy strikes when constitutional and

environmental factors mean the baby is surrounded by carers who did not gain their own licence or for other reasons, fail to pass on that ability. The aetiological roots of schizophrenia lie in an unconscious conflict within the child as well as in the family about allowing them to become an individual, leading to over-dependence and lack of development of a core personality (Searles 1993). The central conflict in the condition is speculated to be around the question, not of how to relate but whether to relate to others. Rather than allowing mutual co-existence, relating in this situation brings a threat of annihilation. Right from the beginning, repeated patterns of patients' experiences mean that they develop pre-reflective organising principles of non-being and unreality of the self, in order to ensure the survival of the other (Stolorow, Atwood & Orange 2001). I understand the theory of High Expressed Emotion (Brown 1985), accepted in psychiatry as a family trait as related to this view. The common theme seems to be that of psychosis as the loss of opportunity to cohere as a self, due to interpersonal processes. When growth is unhealthy and insecure, psychosis may represent a desperate need for a reorganisation of our self, as Williams (2012) suggests. Several patients spoke of their "symptoms" as symbolic of the work they needed to do to reclaim their lives. Patients suffered in their early lives and during treatment through the inability of psychiatry to recognise the need and failure to provide such facilitating environments. With relationships crucial to the environment within which that work needs to be done, their neglect in psychiatry aggravated patients' unconscious fears so the professional was experienced as a persecutor rather than a refuge. My data suggests that the dominant biomedical view may, tragically, have led to the continuation of psychosis if patients' health-seeking impulse had not led them into the Movement.

5.4.2 Psychiatrists and relationships

The possibility of therapeutic relating had first attracted the young doctors to psychiatry as a specialisation. Whilst some went on to identify with patients and explored their own problems, others sought distance and clear blue water between themselves and mental illness. Stark differences and conflicts arose between those who stayed within the biomedical paradigm of their training, which emphasised medication as the instrument of treatment and others who saw relationships in that role. The necessity of '*use of self*' (Rowan & Jacobs 2002), seemed to be the dividing line between different schools of psychiatrists and between the profession and

patients. Similarly to the need for an integration of the subjective and the objective in patients, psychiatrists felt that the 'use of self' helped them integrate as a professional. If psychosis is objectification of the self, a return to being a subject needs recognition by another subject (Fromm-Reichmann 1959; Stack-Sullivan 1971). 'Use of self' is akin to the kind of therapeutic partnership requested by Taylor (2014) and my patients, one where the healer makes her mind available to the sufferer for the purpose of recovery. The emphasis on the empirical and the objective in psychiatric training however, separates the professionals from intangible and subjective aspects of themselves. The poetic references made by my sample to conversations as surgical theatres or reigniting existential fires, expressed the task in psychosis of 'seeing with the heart' (St. Exupery 2000). That most in the profession do not 'see with the heart' was betrayed by these psychiatrists' fears of being misunderstood and accused of psychotic thinking by the mainstream, perhaps evidence of battle between the symbolic and the symptomatic approaches to life (Whitmont 1992). Others would describe such conflicts as loss of understanding of our existence as process and relationship or, the power of emotional connection and depth (Bohm 1996; Hycner 1993). These authors are all pointing to the existence of something beyond the obvious, of life as a quest rather than simple existence and 'man' not living for bread alone. Even though feelings and relationships had been the initial attractions into the work, those aspects had become mere tools, turning psychiatrists away from the complementarity of poetry.

Science started from the epistemological position that direct observation of phenomena and relationships between them could explain everything. Modern physics (Bohr 1977; Bohm 1980) tells us however that the observer is also a natural phenomenon. Relationships between the observer and the observed matter therefore, whether the observed is an apparatus or a being. It is therefore much more likely that attitude and relationship change the data when both participants are human as in a psychiatric encounter, so that different psychiatrists will see the same patient differently. Difference in attitudes towards the patients and the work must explain some psychiatrists' ability to remember interactions with patients from 30 years ago whilst others were unable to bring any such experiential evidence to the interview or connect with their own motivations for the job. Some felt their view of psychosis and work with patients changed

once they recognised the meaning of relationships whilst others tried hard not to change, even in the face of evidence for the need.

Something very human may be going on in rejecting a complex understanding of psychosis and insisting that the need in psychosis is for drugs, not meaning, hope or relationships. Recognising the complexity would lead to practitioners recognising their own unmet needs in that regard and to wrestle with the greater complexity of their role. My findings lead me to agree with Stolorow et al. (1987) that the pervasive reified image of an isolated mind exists due to our common fear of the 'unbearable embeddedness of being'. Phenomenology understands psychosis through exploring the patients' anomalous self-experience but in order to do so, we have to engage using our self (Gallese & Ferri 2013). He suggests that understanding comes through "perceptual experience in our bodies as a flash of lightning rather than through inference by analogy" (ibid. p. 2). Taylor, in her account describes the paradigm conflicts thus: "madness practitioners proffering remedies across a gulf of professional expertise or the sufferer and healer drawn together in a therapeutic partnership....making your own mind available to somebody else, to help them recover" (Taylor 2014, p. xii). Difficulties in engaging with human depth may be leading to the need to simplify existence and prizing materialism. The necessity of empathy may be ignored because of the inherent pain in connecting with the wounds in patients' and psychiatrists' selves. Data about the reluctance to use group process suggests psychiatry trades the richness and complexity of phenomenology for a narrow medical view because of the toll upon practitioners. Resistance to empathic understanding within psychiatry turns psychosis into something unintelligible rather than something very human, according to Stanghellini (2004). Eilan expands on this theme saying (2000; p. 109)

The reason we find normal empathy psychologically impossible is not only the cognitive dissonance from everyday beliefs, but, rather, our very deep resistance to allowing ourselves to engage fully, by simulation, with the kinds of world- and self-losing emotions embodied in these schizophrenic states.

Those psychiatrists more able to offer relationship and phenomenological understanding to their patients seemed comfortable with their own humanity. Unable to differentiate between

psychosis and other distress, others related to patients via fictional characters rather than the flash of lightning in their own bodies. Since there are no words in symptom-based psychiatry for the symbolism of extending a helping hand, the power of that encounter is ignored. The narrow psychiatric focus may be designed to prevent encounters with the soul and avoid the triggering of fear, fragility and dread through the burden of relationships.

5.5 Systemic Problems

Finally, I discuss how treatment and training systems in psychiatry impact the needs for meaning, hope and relationships and lead to conflictual relationships. To understand systems, every aspect needs to be considered together so it would not make sense to distinguish between patients and psychiatrists. Participants raised concerns about systems design preventing due attention to the complexity of psychosis, patient needs and the loss of morale amongst psychiatrists. Others spoke of how the lack of holism in the systems resulted in the dismissal of the experiences of patients and carers whilst amongst psychiatrists it led to difficulties in understanding and managing work stresses. The disciplines of organisation development, psychodynamics and social psychology have plenty to say on these issues.

5.5.1 Systems design

Studies of organisational psychodynamics (Menzies Lyth 1960; Jaques 1955) suggest defences are employed against awareness of difficult feelings experienced at work. Their paradigm became known as 'social systems as a defence against anxiety' (ibid.). Menzies Lyth (1960) recognised that nursing training promoted systematic avoidance of anxieties inherent to profession rather than learning to work through them. 'Defensive techniques' were used to avoid underlying anxieties arising from the job about pain, mutilation and death. Although the defensive techniques ameliorated the feelings of severe anxiety, they were unhelpful in the long term, leading to a lowered morale. Schwartz (1990) found a similar withdrawal from reality into organisational narcissism in a very different industry, that of car manufacturing. He related this tendency within major US organisations to human anxiety about finitude, vulnerability and mortality. Back in Social Care, Stein (2000) developed this conceptual space of 'social systems as defence against anxiety' into 'social systems as an envious attack'. He found multi-directional destructive envy to operate in all human systems in refusing to work collaboratively.

All parts of the social system may be interdependent but constant attacks on linking with or learning from others are experienced (ibid.). Such attacks are directed at everyone who might possess something desirable or anything that evokes fear through a perception of our fragility and finitude. Kapur (2009) writes about healthcare organisations hijacked by deeper, primitive and unconscious forces towards destructive purposes. The literature above uses Bion's basic assumptions (1961), to suggest that every group, including the NHS, operate at two levels simultaneously: knowing what the individuals and the group are there for and, actively sabotaging the work through attacks upon others. The more uncertain, ambiguous and anxiety-provoking the task, the greater the basic assumption disturbance and attacks upon those on whom the group depends.

From the data I have presented already, the task facing psychiatrists and the patients has all the attributes likely to bring perversity and sabotage to the fore. Psychiatrists may use professional power to emphasise the objective and dismiss empathic engagement due to unconscious fears and the pain of dependence. Bell (1996) provides an account of how our primitive minds confound ordinary interdependence with helpless dependence, with human hatred of weakness causing the system to stamp down hard on patients. He cites practices in welfare states and psychiatry where attempts are made to foster independence amongst patients by deeming relationships 'unnecessary' and withdrawing them. Luhrmann (2001), documents social and institutional practices of psychiatric and medical training which lead to physical and emotional exhaustion as well as humiliation. The effects of such experiences among professionals were to react defensively and enviously against the weak, in their work. Sane, reasonable and rational caring behaviour is not to be automatically expected therefore in care systems, with efforts needed to prevent perverse envy from destroying relationships. The discord within psychiatry, that between psychiatry and patients or the Movement could be understood as part of this dynamic of trying to avoid contact with dependence, mortality and fragility. I found evidence of insecurity among psychiatrists about theoretical and practical bases of their practice and blaming of patients or others within the profession for bringing up difficult feelings. It would seem that perverse dynamics are at work when patients are treated cruelly and made to "feel like shit" in treatment and, psychiatrists worry about being dubbed psychotic for privileging relationships. This may explain the avoidance of emotional engagement in

psychiatrists, with management of primitive existential anxieties becoming more important than helping patients. Complaints about fidelity to protocols and agendas of treatment/training organisation rather than patient care may also be related to such anxieties. A Japanese psychiatrist, Doi (1971) spoke of the importance of the concept of 'amae' whereby a person 'depends and presumes upon another's love or basks in another's indulgence'. He found western culture to lack the concept of such *primary love*, focussing too much upon independence so that in the process, some basic human needs are misunderstood (ibid.). Not seeing patients in their wholeness and splitting their care into tasks performed by a range of professionals may protect psychiatrists from difficult affects but leaves both sides with unconscious damage (Arieti 1974; Fromm-Reichmann 1959).

My findings and the literature suggests that perverse, uncaring social care systems emerge because to be human is so complex. The problem of conflict in psychosis treatment seems to be a human problem with our ontology, not solely for psychiatry. Meaning, hope and relationships may be basic human needs but there is evidence that we sabotage ourselves. Rather than a deliberate, evil design to dismiss and denigrate patients, individual psychiatrists and the system are simply reacting as human systems do. In writing about healthcare culture in the NHS, Ballatt and Campling (2011) refer to the necessity for kindness in delivering good healthcare, since kinship and connectedness are the key reasons for people choosing this work. They highlight the difficult tasks which face personnel when rationality and good intentions on both sides are willed but rarely manifest, due to the psychic and social complexities outlined above. They found medical life to be dogged by a sense of inadequacy, guilt and self-blame on part of practitioners, with many attempting the impossible task of vicarious repair of their past (Zagier Roberts 1994). The stresses of caring and the need to remain unaware of them are so great that primitive defences of types described above are used to cope. In the final analysis, kinship and spirit of community may be the initial driving forces of any care system but they get marginalised because efficiency and individualism insulate from the pain of life. Psychiatrists are left to wrestle alone with such complex questions because the wider society has transferred its responsibility to them (Foucault 1960), a responsibility that would be too much for everyone (Ballatt & Campling 2011). In this situation, my sample of patients make do with the basic care provided within psychiatry because they know those

needs would remain unmet in the wider world. The old asylums may have played the role of the 'stone mother' to offer succour to the patients, the era of 'community care' has killed the mother but the children still roam looking for the breast (Taylor 2014).

These disappointments and the on-going quest led to the rise of the Movement and my sample moving towards its bosom. Such developments have led to changes through bringing about a new breed of professionals, experts through experience, and new fields in academy, such as Mad Studies (Russo & Sweeney 2016). These are groups which some of the patients belonged to, aware of their needs for meaning, hope and relationships through attending to their experiences and sought them enthusiastically. Seeing the illness as a constructive spur to growth necessarily produces a chasm between patients and psychiatrists (Moritz et al. 2013), because the systems continue to reject complexity by imposing simpler biomedical narratives, as I found.

5.5.2 Drawing parallels within psychology

Interestingly enough, psychoanalysis, the profession most critical of bio-psychiatry faced a similar forced paradigm shift towards complexity and relationality. Mitchell (1993) critiqued and found classical psychoanalysis to operate from a similar premise to positivist science, ignoring questions about its claims of rationality, expertise and a privileged insight into reality. His analysis of Freud's case study of Dora and critique of classical psychoanalysis (ibid.) has parallels with my findings, with the disregard of context and subjectivity in psychiatry. In the Freudian framework, pathology was generated by repression of biological drives and health attained by accepting rational interpretations. This tendency within psychoanalysis related to its materialist origins and has parallels with psychiatry's focus upon the brain, not the soul (Luhmann 2001, Frattaroli 2001). Systemic difficulty in integrating psyche with soma led to the cruelty experienced by my patients in psychiatric practice, a problem once shared by psychotherapy.

Excising the subjectivity of the doctor and the patient from psychosis treatment may seem like clever solutions to the problems of our humanity. By abstracting from reality and removing the emotionally difficult from our frameworks however, we lose much of significance in human life.

This is where conflict is created in psychosis as the paradigm dismisses the most intense and disturbing experiences of patients' lives and their needs for hope and understanding within a relationship. The estrangement from self, which is the definition of psychosis continues because the experiencing organism is divorced from feelings and intuition (Rogers 1951). Jungians also considers ethics, morality and meaningful existence to inform the basic motivations in life, these in turn being founded upon feeling and intuition (Whitmont 1992). Rational and abstract understandings don't move or touch us in the way that emotions and intuition do; another language is needed for non-rational and intuitive realms of functioning. As modern physics recognises the effect of intention upon particle behaviour, psychiatry needs to acknowledge that consciousness is only one aspect of the human psyche (ibid.) Most schools of psychology emphasise meaning, hope and relationships as essential to the self, in health and in psychosis.

5.5.3 Drawing parallels with wider literature

We can now reconnect with McGilchrist (2009) and his impressive survey of the history of western culture. He found a gradual trend over the past two thousand years towards anonymity, impersonality, rationality, abstraction of thought and perception and away from spontaneous synthetic-intuitive thinking. He attributes these cultural and individual trends to human neurological structure and the dominance of a Left Hemisphere way of being, asserting these aspects to be characteristic of schizophrenia or psychosis. He is supported by Sass (1992), who saw parallels between modernism and psychosis with hyper-reflexivity, defined as the dominance of existence by thought and abstraction, in both. Robbins (1993), a psychiatrist writing about schizophrenia reached the unsettling conclusion that psychiatry was far from objective about its treatment and knowledge and reproduced the primitive mentation characteristic of the disease process. I deduce my findings in psychiatry to be a fractal of this social condition.

I use McGilchrist's thesis to pull together my ideas on the decisive influence of social factors upon the development of psychiatric systems. At its core the idea concerns metaphor, something uniquely human which makes it possible to understand everything in terms of something else, with this something being experienced in our body. Metaphor is how we communicate between our embodied being and the world. He gives an example of how a

comment such as 'It's warm in here' might be interpreted by the two hemispheres. The Right Hemisphere would see it as a request to open the window by using data from its embodied empathy with the person making the comment, whilst the Left Hemisphere is more likely to see it as meteorological data because it prefers single meanings. By detaching from context and body, the Left Hemisphere insists upon words meaning just what they say, reminiscent of the concrete and disembodied nature of thought in psychosis, lacking in empathy. McGilchrist (2009) contends the Left Hemisphere's hankering for certainty without using the Right Hemisphere's ability to live with complexity has come to dominate western culture, whilst Eastern cultures maintain a better balance. With NHS psychiatry a product of western culture, I believe it is similarly dominated by the Left Hemisphere tendency to abstract and analyse, searching for objectivity and certainty and in difficulty with the flow of life. The psychiatric gaze is similar to the schizophrenic stare because instead of pragmatism and bridge building, a solipsism dominates (Sass 1992). Instead of utilising the available wide knowledge base to inform itself and ameliorate the effects of 'social systems as an envious attack', the Left Hemisphere focus upon objectivity and old science leads to the exclusion of subjectivity and complementarity. It may well be, as the poet T. S. Elliott said that, 'we can't bear too much reality', and so turn our eyes and soul away to construct another world, much like the patients in psychosis.

5.6 The way forward

It would seem we urgently need to find a way to help psychiatry engage with the fact of human self emerging from interaction with others, not atomistic isolation (Schoore 2005). Modern biology urges replacing the essentialist concept of "individuality" with one that fits with the larger systems approach because of the difficulty in distinguishing where an organism ends and another begins (Gilbert and Epel 2009). Amongst humans therefore, they find it impossible to tell if our gut, a part of our immune system which includes countless micro-organisms, should be considered a part of us or not, due to widespread symbiosis throughout the animal kingdom (ibid.). In light of the moves towards holism in Biology and Physics, psychiatry is at odds in insisting upon abstracting psychological distress from social context and locating it within the body.

5.6.1 A scientific approach to the problem of empathy and self

Perhaps we could approach empathy and self by breaking it down in line with the Left Hemisphere bias without compromising on the message, like good teachers tailoring to all their students. If McGilchrist (2009) is correct, the Left Hemisphere is not deliberately setting up obstacles, it's simply behaving in line with its nature. The Right Hemisphere may need to come up with ways to make the picture whole again, and meet the needs in both patients and psychiatrists. McCluskey (2005) appears to have done just this in her work 'To be met as a person' and I suggest it points a way forward in psychosis treatment. She uses attachment theory as her launchpad, possibly the most biological of psychotherapeutic theories, based as it is in the survival function of the bond between infant and caregiver, both driven to seek each other. Her model uses the care-giving and care-seeking systems with five other biological systems, used by humans to monitor and address their relational being and ontological security needs.

The patient's care-seeking system is aroused at a point of crisis, but gets over-ridden by their fear system so they do not seek help or do so inappropriately. The fear may be expressed by behaviours such as flight (submission), fight and/or flight (dominance, submission or both) or freeze. The person is thus at the mercy of their fear system and their internal psychological environment plays a big part in this so that in psychosis, the default would probably be to withdraw further. The psychiatrist's first task is to help the patient regulate the fear system because as long as that is aroused, no exploration or movement into health is possible. Appropriately trained psychiatrists in McCluskey's concept of Goal Corrected Empathic Attunement (GCEA) could offer the kind of help the patients asked for and need at this point. Just as with any carer, attunement can be optimal, sub-optimal or very off-key but the care-giver can develop their sensitivity to the contact between their care-giving system and the patients' care-seeking systems, without going through expensive and extended psychotherapy training. Rather than remaining a vague therapeutic concept, McCluskey (ibid.) asserts people can be trained to empathically attune through learning to monitor and observe physical and emotional responses in self and others. Although the training has not been used in working with psychosis to date, personal communication with McCluskey (2013) suggests psychiatrists have commented upon its potential usefulness. Operationalising the self as a biological system could

enable psychiatrists to monitor their own and patients' emotional responses and help them explore their needs within a secure relationship.

Another strand of training to help psychiatrists develop skills in observing themselves and others has been developed by specialists in psychotherapy. Hinshelwood & Skogstad (2002; p 111) developed organisational observation for psychiatric trainees "stuck in a culture that aimed to induce in them a distanced apparently 'scientific' attitude to their work." They found an attitude of reification within psychiatry where patients were viewed more as objects of study not human beings to relate to. Their observations led them to develop a method to make professionals aware of the psychodynamics in operation through observation and group discussions. Their method develops the practitioners' ability to hold in mind a loose cluster of expectations and conceptions whilst remaining open to their own experiences. They may be confronted with experiences that, initially at least fall altogether outside the bounds of their training and ability to understand, such as thoughts and feelings not belonging to them. Skogstad (2004) suggests however that by adopting the 'third position' (Britton 1989), psychiatrists are more able to stay open to a range of experiences instead of prematurely shutting down due to fears and anxieties. Schon in his work *The Reflective Practitioner* (1984), and Sennett (2008) in *The Craftsman*, also extol the virtues of reflection though they come from very different fields of professional development and sociology, respectively. All this work refers to the greater levels of individual and professional satisfaction to be gained through learning to reflect-in-action. People want to be good at what they do and be recognised for it. Others such as Sher & Nicolini (2004) have developed mechanisms to bridge the distance between our culture and our ontology, such as *Reflection Action Learning Sets* (RALS). RALS take the ability to step back and reflect to the next level, by creating reflective systems within services. With such reflective principles embedded within systems, the risks of a retreat from dialogue and relationships into solipsism are much reduced.

All the research focuses upon staying with the richness of life by using our subjective experience instead of escaping into the blandness of objectivity. Open Dialogue is one such reflective system to pay equal attention to patients, carers and all professionals without the usual strict hierarchy (Alanen 2009). The focus is upon patient needs, whether physical,

psychological, social or spiritual with a recognition of the centrality of their subjective experience. As we found, both patients and psychiatrists need help in reflecting if they are to prevent rushing into simplistic solutions for psychosis. The process requires the facilitating environment of a whole reflective system, offering everyone involved the necessary holding without which the terrors of psychosis become unbearable (Hinshelwood 2004). In the matters of managing difficult emotions and our capacity for madness, we are at an early stage of evolution where we are more likely to hurt than help (Eigen 2010). We may need to think about the timetable of developing our ability to integrate the synthetic intuitive attitude with the analytic objective attitude in thousands of years rather than decades (ibid). I would therefore like to end on a hopeful note from one of the patients which resonates with the authors I have cited throughout this discussion.

“the wheels of mental health grind very slowly but they are turning. I think that is the important thing...if you accept that it's never going to be fully changed in my lifetime but....” (“Keats”)

We are on a slow and painful path in the evolution of our abilities to manage life and its complexities, with the conflicts in psychosis treatment offering necessary guidance.

5.7 My contribution

Counselling Psychology demands a ‘rigorous empirical enquiry with a firm primacy of the counselling or psychotherapeutic relationship’ (Division of Counselling Psychology, 2005; p.1). I believe that my study meets that demand by producing a trans-theoretical framework which describes the conflict within psychosis treatment as deriving from a systemic and cultural difficulty in providing the requisite therapeutic relationship. Supportive systems and relationships are essential in providing hope and meaning so avoiding conflict in this setting seems impossible, currently.

My study protests against the elevation of impersonal objectivity and abstraction through a strong case for attention to subjectivity. It is therefore a small contribution to the scientific and social trends in moving away from old objective science towards a new paradigm. I see myself

taking a scientific approach by providing empirical evidence for human ontology and our dialogic nature, in the way of studies within Feminist and Race studies. By rejecting the necessity for bringing emotional responsiveness and both subjectivities into the therapeutic interaction, psychiatric systems maintain traditional distinctions between the ill and the healthy, the healers and those in need. I assert that such positions of neutrality and objectivity taken by these systems unwittingly uphold traditional power structures. Personally, the links between the systems and wider social trends towards abstraction and impersonality are the most pleasing contribution of my study. This finding, that the complexities of human nature and the tensions within are reflected in psychiatric social structures, is the most important by locating the problem within systems rather than individuals. I am aware that this is not a discovery; indeed I have cited some relevant sources within my study. I am also aware that we are in the Keats-ian territory of 'negative capability' again, the difficulty humans have in staying with uncertainty and complexity. My unique contribution perhaps, consists in presenting specific findings about the necessary attention to human subjectivity to understand the divide in psychiatry, and link it to our wider culture and individual existential difficulties.

In suggesting that psychiatry merely reflects western social trends towards abstraction and simplification whilst moving away from holism, psychology must be similarly affected. In terms of the practical impact of my study, my hope is to issue a challenge to the training and treatment in both disciplines and demand change. Future psychiatrists and psychologists (including psychotherapists) should achieve a fuller understanding of psychosis and the needs of their patients. Psychologists may have an important role here, something that Milner (1987) recognised a long time ago, to help others recognise the essentiality of conflict in life, that the answer lies not in eliminating it but learning to live with doubt and unsatisfied need. The psychologists' job is to make it possible to hold judgement in suspense until the claims of all sides can be integrated in designing a whole reflective system. My chief contribution would then have been to help identify the need to develop systems to support everyone involved in this most difficult of jobs, helping a soul in its quest.

I am pleased to contribute to the Counselling Psychology and psychotherapy traditions of challenging paradigms, in locating the conflict in our ways of being instead of individuals or

groups. My research has highlighted more consequences of modernity upon psychiatric treatment and may be a spur to further research into interactions between modernity and subjectivity. Practitioners need to learn to live with complexities in life, embodying an ability to think whilst being present to psychotic process. As our discussion shows, developing this ability can help doctors understand and support their patients better. Psychological practitioners, using their specific research and therapeutic skills may be able to contribute towards creating more caring environments and disseminate those findings. In this way, I hope to contribute towards achieving a better balance between our needs and environments, creating responsive surroundings and learning to live with what we can't change.

5.8 Further reflections, limitations and next steps

My initial ideas about the research did not reckon with the complexity involved in the psychiatric treatment of psychosis and helping the various sides understand each other. Although I knew about the differences between mainstream and fringe psychiatry on this issue, I vaguely attributed the conflict to individual psychiatrists. Through the study, I have gained enormous empathy and humility about systemic issues and difficulties faced by both sides and am pleased to have understood much more. I am aware of a tension in me about having gone from the need to rein in my bias against the profession to developing empathy towards it. The tension derives from my primary allegiance with the patients because I feel as if I have betrayed them. That is perhaps another example of being caught up in binary thinking because findings that blamed individuals would hardly have been helpful to patients. The tension helps me to recognise the changes in myself through this research, providing evidence of new understandings leading to changes. I have given voice to a recognised marginalised group and may have discovered the suffering in a previously powerful group. The discovery may help both patients and psychiatrists if changes were to occur in line with findings.

I concede that my sample could have been more diverse and representative with only two male patients and two female psychiatrists. It is possible for it to have biased my findings but in line with most qualitative research, I am not claiming generalisability. My findings relate only to the experience of psychiatric treatment within the group I interviewed so I would encourage anyone wanting to apply the findings elsewhere to make their own assessments. It is possible to

question the relevance of my study for psychology or psychotherapy because I researched psychiatry, but I would respond that I studied 'conflict in human relationships in states of high distress'. It would be possible to take things further through comparative research and investigate patient relationships with psychiatrists and psychotherapists and psychologists, to understand how the range of 'ways of professional being' affect findings. I also acknowledge my study does not study individual differences between the psychiatrists who were able to transcend the limitations of their training and others who could not. Perhaps that would also give a comprehensive picture of reasons for conflicts within relationships.

I now believe that limitations were placed upon the findings by my blindness to vulnerability amongst the psychiatrists. My skewed perception of power dynamics meant that I did not see any fragility in psychiatrists. Only in the later stages of the analysis did I pay attention to my counter-transferential worries about their emotional state during the interviews. My findings suggest that psychiatrists believe and expect to know all they need when they qualify but are then confronted with the falseness of that view. My questions ask psychiatrists to focus upon their experiences of relationships which expose personal vulnerabilities and gaps in their world-views and, here I found myself worrying about damaging these previously all powerful professionals. Exploring professional identity and relationships in psychosis treatment may raise ethical issues because challenges are posed to professional belief systems and an inadequate sense of self. With the patients, I may have experienced blindness of another kind in expecting them to find it easier to have an open and honest conversation with a professional like me. I may have been presumptuous about our ability to work together towards bridging in psychosis treatment within the space of two meetings. I neglected the impact of power differentials and patients' negative experiences with professionals so I believe that I needed to be much more mindful of those factors. I did not sufficiently consider the pain evoked in discussing treatments and relationships with those involved in providing it, however familiar they were to such discussions with others within the Movement. At least two participants were visibly affected by the questions, with their distress palpable, others may well have been affected without my awareness. Such distress points to the necessary limitations of the strength of research relationships and the need to create a more holding environment.

If I had considered the impact of these factors upon participants' capacities to engage with the research, I would have designed a project with an in-built bridging element which nurtured a collaborative spirit over time amongst. Such a model with co-researchers from both groups, may have facilitated better bridging and understanding of the conflict. My subjective experience suggests the questions evoked deep emotions which remained out of awareness so alternative ways of dialoguing and communicating need to be found. In a collaborative project, the participants would have had a sense of ownership in the research and felt more able to bring in subjective experience as data. The resulting analysis would lead to uncovering more unconscious material and perhaps a more incisive discussion.

Real limitations arise in building a bridge of relationships when personal and professional selves are threatened and the two sides are fearful of knowing the other. This is precisely the situation highlighted in my findings, with patients experiencing the professionals to be mainly uninterested in dialogue and the same obtaining within the profession. A collaborative study might also have come up with better policy outcomes by overcoming some of the inherent barriers through the process itself. These challenges do not mean a relinquishing of my aim. I now have a better understanding of the difficulties in bridging with so much at stake in terms of personal and professional selves. I shall need to work harder as simply conducting the research is not enough to reach my aim, a bridge of mutual understanding will only form through publicising my findings amongst psychiatrists and the Movement. I hope to actively disseminate the findings by presenting, writing and collaborating with interested parties.

The necessary house of psychiatry built upon systems supportive of our existential needs for meaning, hope and relationships is not quite what I imagined when I set out. Detailed attention to our cultural difficulty with dependence or our need for others, explored in Balint's concept of primary love (1968) or Doi's concept of 'amae' (1971) is needed. The patients, the Movement and professionals need each other to build and maintain such a house of psychiatry. Such bridging and addressing of conflicts may help stop the monologue of madness in cases such as the patient in my introduction who was left alone and abandoned in his own treatment.

5.9 Conclusion

I embarked upon this research to understand conflicts between patients diagnosed with psychosis and their psychiatrists. I now recognise that the problems derive from our difficulties in reconciling with human frailties so we create systems which blind us to our own reality. I have provided empirical data for 'psychosis treatment as a conflict-ridden system' in the vein of Stein (2000) 'social systems as envious attack'. Although I believe my perspective on the problem to be original, I am aware that the central message is our need to 'reckon with human fragility', something that humanity has struggled with for millennia. I have highlighted the necessity of recognising the patients' shattered psyche and creating an environment where they can tell their story and integrate but also our aversion to the task because it puts us in touch with the potential for fragmentation in all of us. I have a greater appreciation of the job as a result of this study and hope that I have made a contribution towards others gaining a better understanding.

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Appendix 1

Informed consent form

My name is Tarun Pamneja. I am a Doctorate in Counselling Psychology and Integrative Psychotherapy student in the last year of training at the Metanoia Institute in London.

I am presently conducting qualitative research into the British mental health system and how it could be improved to better meet patient needs. I aim to interview Consultant psychiatrists as well as people with extensive experience of using the system, generally known as 'survivors'. There is an enormous debate into how psychiatry and psychology generally devalue and invalidate what patients themselves think of their problems and how they want to be helped. There are pockets of good practice as well however and lots of patients who are happy with the help provided. Lots of psychiatrists and psychologists have also expressed unhappiness and dissatisfaction with the way that the system works. The research will aim to build on the good practice examples and to imagine a system that addresses these concerns and brings out the best in our collective humanity.

Through this research I hope to develop a picture of the gritty realities of the mental health system and would therefore request that you focus on your direct experience of the system. Your feelings, thoughts and experiences are critical to reaching an understanding of what works and how it could work better.

I plan to use a methodology known as Framework Analysis as the method for analysing the interviews. This method will allow me to draw out the main themes and ideas that the participants express and discuss any similarities between my findings and current literature on this topic.

I will be interviewing twelve to fifteen people in total who will all be asked broadly the same questions. All interviews will be recorded and should take no more than ninety minutes. The recordings will be retained by me and will remain confidential between myself and my supervisor at Metanoia Institute. The interviews will be transcribed but those transcriptions will have all identifying details removed before they appear anywhere in the final research or any publications that may result.

Participants are requested not to disclose any details which might threaten their own or their client's anonymity in order to maintain confidentiality. Participants will have the right to withdraw from participation at any time during or after the interview without having to give a reason.

Participants are asked to give permission for anonymised transcripts to appear in the research dissertation or publications arising from it. In line with the British Psychological Society rules, confidentiality will only be breached if information concerning harm to self or others is disclosed.

Should you at any time feel that you have questions or concerns arising from any aspect of this research please contact me on my email address at tpamneja@yahoo.co.uk. When talking about your experiences, you may find yourself re-evaluating them. If you should find yourself being troubled as a result of our discussion, please contact myself in the first instance on 07852 538310 or the above e-mail. You may prefer to access the following:

Your personal therapist or Supervisor

Appendices

Your Employee Assistance Programme or Counselling provided at work
My supervisor Professor Vanja Orlans at the following address and phone number:

Metanoia Institute
13 North Common Road
Ealing

0208 208 1235

I agree that I have been made aware of the aims of the study and the procedure for collecting the data. I understand that all the data will be kept confidential and will not be individually identifiable. I am aware that I can withdraw my contribution and myself from being included in the study at any time.

Participant's name

Signature

Date

Tarun Pamneja

Date



13 North Common Road, Ealing,
London W5 2QB

Telephone: 020 8579 2505

Facsimile: 020 8832 3070

www.metanoia.ac.uk

Tarun Pamneja
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies
(DCPsych) Metanoia Institute

16th February 2009

Dear Tarun,

*Re: Conflict Within Psychosis Treatment in the English NHS: Investigating the
Experiences of Patients and Psychiatrists*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Prof Vanja Orlans
Faculty of Post-Qualification and Professional Doctor-

ates on behalf of Metanoia Research Ethics Committee

Registered in England at the
above address No. 2918520

Registered Charity No. 1050175

Appendix 2

Interview Questions

Patients

1. Could you tell me a bit of your story in psychiatry and how you came into it?
Include story of diagnosis, what it is and overall experience?
How do you understand your illness, now and then?
2. What is your current involvement with NHS psychiatry?
How are you involved?
Feelings about the involvement? Conflict?
Do you feel meaningfully involved in your treatment?
How do you understand your diagnosis and treatment?
3. What is your involvement with the SUM?
How did it come about?
What are your feelings?
How does it compare with your involvement with the NHS?
4. How do your relationships in the NHS compare with those in the SUM?
What are the differences? Similarities?
What do you value the most? the least?
5. What have been your best experiences in psychiatry?
What made them good?
Something about people?
What it meant?
6. What makes good treatment?
What do you need from others?
What do you need from yourself?
What do you need from the NHS system?

Appendix 2

Interview Questions

Psychiatrists

1. Please tell me about your psychiatric training and experience?
Where did you train?
Significant experiences?
What attracted you to psychiatry rather than other specialities?
2. What is your understanding of psychosis and schizophrenia?
Has your understanding changed through your career?
How do you make sense of those changes?
Is there anything qualitatively different between psychosis and other major diagnoses?
3. What is the doctor patient relationship about for you?
What is it about in psychosis?
How do you go about developing it?
Any particular difficulties in delivering?
4. How do you understand the concept of 'critical psychiatry'?
Experiences of critique?
Feelings about critique?
6. What makes ideal treatment in psychosis?
How do you go about delivering it?
What do you consider to be the barriers?

Appendix 3

Segment of interview with "Doug"

Doug- I have had a lot of experience I suppose because I have tended to specialise in working in that field so...in the end I have probably devoted most of my career to working particularly with people who have....treatment resistant complex illness which is difficult to treat..... 00:05:28-3

TP- Could you say a bit more about your interest in that and your experience of that? 00:05:34-5

Doug- Yeah, ummm I.... when I was training, it always struck me that the more disabled and the more challenging group of patients to work with ummmm that the kind of problems and the difficulties that are generated by working with those particular, with that particular patient group was something that really I found quite an interesting and....positive challenge....and throughout my career I have always been struck by...the....the amount of success and how....beneficial..working with....effectively with people with complex treatment resistant illness is....so although there may be a kind of view that it would be a dismal and rather a depressing group of people to work with, my experience has been that its been a very successful and you know a group of people that's been very rewarding to work with...we have had a lot of people who have made a massive progress in their lives and you know people have surprised me consistently with how well they have done when they've been offered really effective good treatment and support.... 00:07:14-7

TP- Ok, could you say a bit more about what's rewarding? 00:07:17-9

Doug- I suppose the reward comes from seeing people who maybe are in a very difficult stage of their life, whose illness is maybe uncontrolled and has been..... causing them immense distress and personal suffering for a long time and whose lives are in a mess, you know maybe there social functioning is very impaired, their social networks are....sometimes very limited, their personal relationships are really not working at all and..... I guess seeing people go from aa....position like that to maybe functioning quite well, looking at work perhaps, living in a good accommodation...and well engaged in services so seeing people, that will be my ideal to see people going from that kind of situation to a much more healthyone..... 00:08:30-9

TP- Ok, so you thinking about...change in their life situation, change in their social functioning....you used the word rewarding though, rewarding for....? 00:08:45-0

Doug- I guess its rewarding for everyone...its obviously rewarding for the individual to experience that change but its also very rewarding forstaff...for professionals to work with people over a...its often a long-term...work with people who have severe treatment resistant illness....I guess the point I am trying to get across is that for a lot of people what appears to be aa very pessimistic and dismal...situation can turn into something much more positive over a number of years and often does....so.... 00:09:25-2

TP- So but...because I am interested in your personal experience....could you say how its rewarding for you? 00:09:33-6

Doug- I guess I would think it would be implicit from what I said but the reward would be in seeing somebody...ummm...you know get better. I guess any healthcare professional

would enter....ummm this profession for example become a doctor or you know a nurse or whatever for caring medical professional with the hope that you would help people and help them to...recover...and so I suppose the reward comes from....to soem extent the success where that happens..... 00:10:21-6

TP- Reward comes from the success but....and i guess....what I am really looking at is....you know what does reward feel like? What does it bring up? You know...the feelings and thoughts I guess about when you see the person make the changes you have spoken of? 00:10:58-1

Doug- I suppose just a satisfaction of seeing that you have contributed something useful....something good...you've helped other people...I guess that's what it boils down to.... 00:11:13-7

TP- Right...right...you've helped other people.... 00:11:16-6

Doug- Yeah... 00:11:18-0

TP- Ok, ok....Ummm I will come back to that question and about feelings much more....it might seem obvious but one of the things about the research is that I am really trying to get at personal motivations...of what does that reward feel like...because if you have a certain quality of it, it makes people do something in a different way....i guess if you look at motivation and reward generally so that's what made.....might seem obvious but i will pursue it if that's ok..... 00:12:05-5

Doug- Umm yeah...do do, I am in your hands.... 00:12:10-0

TP- Ok, thank you...so what you started talking about through your training....about your attraction to psychiatry and particularly with this client group of long-term treatment resistant...could you say a bit more about the attraction to psychiatry...was that...there when you started your medical training? 00:12:41-9 00:12:35-5

Doug- Think it was to some extent although I wasn't very aware of it...and I suppose I could trace back an interest in psycholgy and I studied psychology even at school....and my family included some people who had worked as health care professionals so I guess an interest in the whole notion of ...of medicine and treatment but also...a slightly broader notion ofi suppose psychological approaches to treatment....was something which I was, I had some kind of interest in....or an inkling of an interest in, even before I started studying medicine and then as I studied medicine, I did find the psychiatric aspect of the training very interesting and really something that fitted nicely with my....own character and enthusiasms..... 00:13:52-3

TP- and so...family interest sparked..your interest...can you say what it was that interested you about...psychology...people? 00:14:14-0

Doug- I suppose it is this interest in people...interest in how people work and why some people...seem to.....some people...experience difficulties in their life and how they cope with those....suppose its the interest in the human condition...I guess i also have an interest in literature and...music and the.....and.....film....and i think my interest in those things also....is in some ways relevant to....you know the...motivation...for why you would find working with people in a more in-depth way...more interesting rather than say working in a technical way in medicine for example as a surgeon or as a physician...so you'll be inter-

esting in fixing aspects of people's physical. structure. I guess I have always been ...i was drawn more into an interest in people's psychological makeup and their emotional lives.....
00:15:30-1

TP- Ok....so...that's what you have been more interested in rather than fixing.... 00:15:40-0

Doug- Yeah, I mean I guess probably both...because the fixing thing is still there I think. I think the drive to fix things is pretty strong....I think in me....so I think its probably a combination of those two actually..... 00:15:57-6

TP- Right...ok...so an interest in literature, films and that you think took you into psychiatry... 00:16:11-8 (i remember feeling very blocked and put off exploration)

Doug- I think to some extent...I suppose its how you try and explain an interest in people, an interest in how people get on, people's relationships, people's...lives...how people choose to live...the decisions people make which may lead them to difficulties or may lead them out of difficulties...you know literature tends to focus on those kind of things in much the same way that psychiatry does....ummm psychiatry in some ways could be seen as a profession which focusses on the drama of life....its certainly is something we are...the things we deal with in psychiatry are the kind of things which feature in literature...umm-mand film... 00:17:00-4

TP- Ok...so could you say more about the drama of your life maybe and how that...whether that had any relevance to this....? 00:17:11-9

Doug- Ummmm (he seems gobsmacked)...I could try....I mean...you mean my personal life.....my upbringing or my... 00:17:17-7

TP- yeah...upbringing and i guess an interest in how that related to your interest in psychiatry whether it was about something about that..... 00:17:26-0

Doug- Yeah.....suppose in terms of my own....upbringing...its probably...more difficult to pin down how that would link to an interest in psychiatry....I would see that as just what's made me the person I am....ummm you know Iin terms of why you choosecertain...make certain choices about work...or profession.....Iguess its in there somewhere... but...its a little bit hard to see.....see the exact....ummmm exact links...perhaps you could try and....help me to work out what you are....trying to get at...?
00:18:25-1

TP- I guess what I am thinking of is...was it something about trying to understand something of your own motivations. something about what had happened in your life that...the drama of your own life that you were trying to understand... 00:18:38-0

Doug- Ohhhh, I see....I see what you are saying...I think not....not obviously if I am honest.....no I can't honestly hand on heart say that...ummm.....no...there's been very little....personal experience of MI in my life....or my family....ummm and....really no experience of severe MI...of the kind that I work with now....mostly....so...its a bit difficult to see...in a literal way....or a kind of direct way where that comes from..... 00:19:22-7

TP- I guess I am not just thinking about MI, I am thinking about you know angst, i am thinking about love and falling out and the experience of...you know a relationship breakup or death...or...any kind of grief..that made you think 00:19:40-8

Doug- saying yes throughout the above sentence..... 00:19:40-8

TP- I would like to know more about this...and 00:19:46-4

Doug- I think probably those are the things which....drew me in...but....perhaps not so much....or not so obviously.....I could be wrong about this. I mean it maybe that I am just completely insensitive to my own life actually and lacking awareness of it....but it doesn't....looking back it doesn't really seem that obvious.....to link to....kind of significant aspects of my own....upbringing or life....You know I was...able to live in a fairly stable..family and...my parents are both still alive for example andalthough they are separated and I guess that has an impact on anybody when they are growing up....umm-mm I wouldn't have said it was...kind of you know....damaging impact that some people...perhaps experienced at times.....so in terms of you know development and finding a way into adult life, I guess i don't really....just don't really see a lot of major issues that have...that have...kind of led me there.....don't know perhaps I need to think more about that...I haven't really thought about it very much to be honest... You could push me further if you would like to and see if we get anywhere00:21:14-2

TP- Well, I could...I guess I am also aware that there are time restrictions....and wanting to know about your.....I mean is that....lets pursue this a little bit further then...so you see your professional...because this is something you have devoted the whole of your professional life to...ummm and you link it to your interest in literature and cinema and you did mention another... 00:22:04-9

Doug- Music.... 00:22:04-9

TP- Music right...ummm those are things you spend a fair bit of your free time..with... 00:22:18-5

Doug- Yeah...yeah.. 00:22:18-5

TP- right so you don't make links between what you experience at work with...when you are listening to the music that you listen to.... 00:22:26-8

Doug- Sometimes I do.....sometimes yeah...i suppose..work informs life and life informs work...so you know you...are constantly....hopefully open to new experience and then trying to make sense of how that fits in with what you already knew.... ...so i suppose its always trying to learn more about ummmm things...that's one of the things that....maybe trying to understand things in a different way.....and that's perhaps what a lot of literature and art does.... 00:23:08-2

TP- Trying to understand things in a different way? Could you use an example of...when 00:23:09-8

Doug- I guess.....I could try to....say for example....sounds a bit of a pretentious one but I will give you this one...say for example.....you know a book like...one of the books by Sartre or something like that...which would focus on a somewhat bleak life existence which would include in it a dramatic scene where somebody was so in despair that they put their hand on a table and put a knife into their hand and it stuck right through the hand into the table so a dramatic scene like that....in my professional life, I do come across very extreme situations a bit like that...what people do...or see quite terrible things and yet its very hard to find a reference for that, you know if you read textbooks or...if you...how mean how do

you try to understand the emotional.... depths people get to to do things like that. How would you try and understand what would drive someone to do something like that? So I think sometimes literature or the arts...give greater understanding or help you to a greater insight into how people actually....get to where they are and what actually drives them to do the things they do...whereas some kind of abstract notion about you know....brain chemistry....might not really help you to understand that very much... 00:24:47-9

TP- Right...so....trying to understand that...that amount of despair...that...whatis there something that...what does it bring up for you when....do you relate to it at a personal level with...? 00:25:14-6

Doug- I think you have to be....if you are a professional working in this field you know I think on the one hand you can't help but empathise....you know you must...if you don't feel for people who are going through...suffering then how could you possibly help them I think...is one of the things I feel really so....that notion of the wounded healer....you must be able to empathise with somebody's suffering in order to be able to help them....but on the other hand you also have to have some kind of emotional distance, you have to be able to separate yourself off from people because clearly if you felt the intense...if you were to kind of try to make a personal bond with every person going through suffering and distress that you work with and really try to be there in the moment of their distress in an intense way you really couldn't survive for very long.....so I think part of the professional training is about building up some kind of not a barrier but some kind of defences to...enable you to try and continue to be helpful and supportive and try to help people.....but at the same time maintain a kind of level of distance which enables you to have a separation from their suffering...you know so you can go home and you know....read your books and live your family life...and all that kind of thing and you don't hopefully take too much of that suffering...away...with you. I think its a very difficult thing to do...you know at times if you are going through a personal period of difficulty in your life, sometimes in my experience...it can be harder to maintain that separation...oddly....if your own emotional defences are slightly down.....then...(sighs) actually you can be more affected by professional stresses and...emotional ...than the kind of pressures that come from professional life or this particular professional life.... 00:27:23-2

TP- Could you say more about that....because that relates to some of the later questions....anyway...about this distance...when you are going through a difficult time in your own life...what do you think it is that makes it harder to maintain that distance? 00:27:51-4

Doug- Well, i guess....in some ways its an obvious answer in that if your own...if you are going through personal stress and your own defences are down...or if your own ability to manage your own...emotional and regulate your own emotional life..is not as good as it usually is because of the fact that you are going through this period of stress and then you add to that...the kind of emotional distress that you experience in the workplace as well, you could see it as simply adding to it and so the point where it might overwhelm your ability to cope with it and then you could perhaps start to feel unable to cope andyou know you could start to feel that you are burnt out or you are burning out or you can start to feel that you are experiencing an acute stress problem yourself I suppose. You couldn't cope with the emotional burden on you...I think for a lot of psychiatrists perhaps...I certainly feel in myself that I go through, i have been through phases where you feel a tremendous emotional burden from being....from working within this...this profession...as I say my own experience has been often that it where there are some problems in your own personal life...is making you less robust perhaps and that perhaps the times when the two

come together...but it doesn't always happen that way. I think sometimes events that occur in a professional setting in themselves can be enough to really...cause a very bad impact on you...for example...suicides or....a SUI where very bad things happen..... 00:29:56-3

TP- Thinking about a recent incident or a recent experience of working with scz, could you say more about something along these lines or how its affected 00:30:13-4

Doug- Lets just try and think.....its difficult to think of an obvious situation recently....I mean in my experience...whenever I have worked with someone who has committed suicide...that's always been a very difficult experience because i think your....your kind of natural professional urge to help somebody and to try and help them to kind of recover is obviously challenged so radically by the fact that this person has made this decision to end their life....ummmm its such...a....its a massive challenge to that professional...ummm to the kind of...to what we are trying to do suppose....and inevitably its very difficult so I think each time I have been through a situation like that, I have always found it a very difficult one.....perhaps I think that's the most challenging...professional problem I have faced...in my career..... 00:31:35-3

TP- Suicide...? 00:31:36-0

Doug- Yeah.... I mean I haven't come across it very often...thankfully but on those occasions where I have worked with somebody and I have occasionally worked with somebody quite closely who has committed suicide, its something which you know does have an impact on...your own life as well your professional work and the team...that you are working with is affected in quite a big way.... 00:32:03-9

TP- I am going to press you for personal experience..if you could talk about a particular example ofbut needs to be scz....of how its been difficult to maintain yourself, regulate yourself.. 00:32:24-7

Doug- yeah...ummmm its interesting looking back...because I have now been working for so long....in this field that actually in recent years...maybe...maybe...one has developed more coping strategies...and maybe I have become more effective at dealing with it but...going back to certain experiences which I had after I first became a consultant and we had a number of....suicides....maybe within the first five years of being a consultant...I think at that time I certainly found it a very difficult experience. It had an impact on me in the same way that it probably would (now he is distancing himself from emotions) as a traumatic event so something that I found I was focussing upon, thinking about outside of work, you know worrying about, maybe also having doubts about our....whether what we had done was good enough...whether we may have let the person down...those kinds of doubts and self-searching...so.....I think and also a general feeling of....a sort of despondency I think. I do think that....when that happens in our professional life, it really does challenge what we are doing in a very fundamental way...if you are...if you see yourself as trying to help people, help to recover and then they make this decision to end their life, it seems to, it always seemed to me like a really big challenge to how do you make sense of that, its a very difficult thing to deal with really? 00:34:23-7

Appendix 4

Transcript and coding from patient interviews

Transcript from interview	Line Coding	Indices	Notes
<i>Can you say more about the relationship with your psychiatrist?</i>			
Yeah, I think for me the way it's worked out is that things have got compartmentalised and i think this maybe somewhat common in the NHS that you have a psychiatrist who does medication and hospital. If you are lucky then you have someone else or other people who do different bits and for the last, since 1992 i've had a care co-ordinator or whatever it gets called at that time, it's varied. Who has kind of been responsible for the talking bit which has left the psychiatrist to do the medication bit and you don't, i've never heard it from a psychiatrist but there is this kind of unsaid thing, talking goes here, medication goes here. The care co-ordinator has said medication goes over here, i don't do medication so it's compartmentalised and then my current care co-ordinator does not feel qualified enough to do any kind of proper counselling so she is then trying to add real counselling ummm as another separate compartmentalised bit and these things come as separate bits	<p>Compartmentalised care</p> <p>Need luck for something other than medication</p> <p>Lot of bittiness</p> <p>Talking sometimes available</p> <p>Compartmentalising is implicit</p> <p>Have to work it out yourself, noone explains</p> <p>Talk therapy separated from medical care</p> <p>Care co-ordinator not able to counsel</p> <p>Trying to add counselling</p> <p>Counselling as another compartment</p>	<p>Patients want integrated care, not broken up care</p> <p>Need for holistic care</p> <p>Talking not integral to treatment.</p> <p>Want proper counselling</p>	<p>The lack of a single relationship of trust affects patients negatively</p> <p>Patients are puzzled by the splitting in service provision and left to wonder if their needs are understood</p>

Appendix 4

Transcript and coding from patient interviews

Transcript from interview	Line Coding	Indices	Notes
<i>What did you want from them?</i>			
Accept, well for me to be able to express it, one for it to be safe to talk about stuff ummmm cos i think risk plays a huge part in that you know, like for example when i was hearing voices telling me to kill my children then that had become so much and i had put up with that for such a long time that ...ummmm I needed to say it to somebody but you say something about, you say that about killing your children and no conversation happens after that, you know its action...	Need acceptance Need freedom to express Need to feel safe to talk Risky to talk Staff prioritise risk Voices kept bottled up Left alone with troubling voices Need to share troubles Sharing leads to trouble Staff don't help me They act to manage risk, not to help	Significance of a sharing, safe relationship where I am acceptable Patient needs trumped by systemic ones Context matters	Patients are in need of safety and freedom to express The lack of understanding of that need and different priorities amongst staff is confusing for patients

Appendix 4

Transcript and coding from psychiatrist interviews

Transcript from interview	Line Coding	Indices	Notes
<i>What was different in this relationship?</i>			
He listened and he gave me an answer. He did not dismiss it and not give an answer. He did not just say, i think you should go away and take your drug, He said because you hear voices does not mean you are mad. Society does not understand - that was normalising the experience so society does not understand it, psychiatry does not. He did not say, it's cos you are ill or do you think it could be Schizophrenia? It's just those words, I've always carried them with me to date.	I was listened to I was answered Not dismissed Concerns taken seriously Answer was not always drugs Voices do not equate to madness Normalised Perhaps psychiatry/society misunderstand Everything wasn't blamed on illness Felt supported by words/attitude	Need to feel valued in relationship Possibility of alternative understandings	Unmet needs for care and respect lead to tensions within patients and their relationships with psychiatrists Patients begin to recognise the complexity of psychosis when they come across alternative thinking

Appendix 4

Transcript and coding from psychiatrist interviews

Transcript from interview	Line Coding	Indices	Notes
<i>Understanding of Psychosis?</i>			
Chronic lifelong mental disorder which is characterised by ummmm problems with...positive symptoms, negative symptoms, thought organisation, cognition and mood...social function....umm you could have physical health...ummmm insight awareness that....is ummm that's characterised by periods of relative stability but also periods where there are relapses	Chronic mental disorder Positive & negative symptoms Problems with cognition, mood and social function Insight Stability alternates with relapses	DSM based understanding Acute and chronic phases	Strikingly different understanding, using words that don't really explain. There is a lack of phenomenology or reference to context or developmental history, just comes out of somewhere. There is a nod to a psychological elements and other understandings but no picture of psychosis being drawn based upon personal experience, as there is above

Appendix 4

Transcript and coding from psychiatrist interviews

Transcript from interview	Line Coding	Indices	Notes
<i>What is Schizophrenia?</i>			
Loss of daily self understanding...a kind of daily obviousness....which you feel you would not have to explain because it is just there. Its kind of like asking how is your right arm. My theory is very much that before you start having psychotic symptoms....that net...that matrix of cultural development and underlying relational order of world making has to break down...and then clearly the brain or the mind reacts with a kind of....securing its position in kind of going back to pre-formed patterns of symbolic world-making to inner patterns so that normality and self-understanding... gets lost	<p>Loss of ordinary self-understanding</p> <p>Loss of very basic ability</p> <p>Loss of cultural and relational matrix</p> <p>Breakdown of the relational order that makes up the world</p> <p>Regression to pre-formed patterns in mind/brain</p> <p>Symbols derived from inner world, not through connections to external world</p>	<p>Supporting matrix of "psychological being" gets lost in psychosis</p> <p>Loss of ability to understand self</p> <p>Loss of ability to connect to others/world</p>	Schizophrenia is being defined in a very sophisticated way, similarly to Blankenburg's loss of footing, something very basic but difficult to pin down.
In non-psychotic disorders people suffer from reality....in psychotic disorders people change reality to avoid the suffering even though the change might not be very effective.....the psychotic person for some reason changes reality and in a psychologically driven psychosis....because the reality is too unbearable....at certain times reality is too unbearable...but I don't think that psychosis is only psychologically driven....I mean there are several examples of all these kids who have been doing very well and they go over to Amsterdam on the ferry, come back psychotic having consumed...large amount of substances over the weekend....so obviously there are toxins...that if I didn't know they had been in Amsterdam, I wouldn't know the difference from another..	<p>Reality changed in psychosis to avoid suffering</p> <p>Change is ineffective</p> <p>Unbearable reality escaped</p> <p>Drug driven psychosis exists, not just psychological</p> <p>Important to distinguish</p>	<p>Reality problematic in all disorders</p> <p>Need to change reality in psychosis</p> <p>Psychological and biological psychosis exist</p> <p>Context important to distinguish</p>	We have reference here to the phenomenology of psychosis in terms of an unbearable reality. We also are introduced to the idea that there is a psychological need to change reality and that can happen. External context and the inner world are both being brought in to understand psychosis

Appendix 5

Charted Framework

Patient experiences of relationships in NHS

Patient demography	Relationship descriptions	Quality of relationships	Conflicts & holdbacks
Nicola, Female, White Scottish	<ul style="list-style-type: none"> Had no notes, no respect, he was intrusive 00:22:33-7 Right in the head or want a period? 00:26:45-2 Statement re not liking bathing kids due to flashbacks used against me 00:40:35-3 	<p>I don't trust them so I lie 00:18:47-0</p> <p>They don't believe in me 00:33:07-7</p> <p>Some staff I've seen, I wonder why they do the job? 01:10:09-0</p> <p>Talking over us or making us leave the room as if we are not equals 01:23:44-3</p> <p>Being treated like children 01:23:06-5</p>	<p>Not helpful, more like an interrogation 00:22:33-7</p> <p>Treatment made voices worse 00:19:49-4</p> <p>They thought I should not be coping as well as I was 00:22:33-7</p> <p>Keeping giving meds that didn't work, made me feel like shit 00:25:22-2</p>
Ben, Male, Black British	<p>Just questions, kept changing meds for no discernible reason 00:07:00-7</p> <p>With this particular nurse, my voices got worse 00:28:33-5</p> <p>They wanted me to lose control and I didn't want to 00:30:48-0</p>	<p>I tried suicide 5 times, no one asked why? 00:11:59-5</p> <p>I filled in a whole book with experiences, they didn't bother reading 00:23:32-8</p> <p>My nurse told me what was written in notes, shocking! 00:43:03-2</p>	<p>Determined not to end up like other patients so stopped medications 00:08:07-9</p> <p>I might have listened if they had 00:25:43-1</p> <p>Only minority of staff care, rest ulterior reasons 00:44:38-4</p> <p>Establishment don't believe in spirits, stuck in their method 01:20:31-2</p>
Fay, Female, White British	<p>They try to be very rational, looking in at me as a phenomenon 00:18:57-1</p> <p>Well, just go back on meds 'cos then you wouldn't need these other services 00:41:29-2</p> <p>Step in & see me as human contradicts things important to them 00:51:59-2</p>	<p>We both know we're not communicating, it's like a bad rls 00:18:57-1</p> <p>A handful of times, stepped out of role & been beneficial, rest of time really negative 00:19:44-3</p> <p>I was gonna say there's nice stuff but no, it's broken but some nice people 00:45:28-6</p>	<p>Only "see me" temporarily mostly they retreat 00:49:39-2</p> <p>They hold so much power over me, judgement has implications 00:09:52-4</p> <p>Until I see the notes, I don't believe anything 00:06:02-0</p> <p>I have disengaged emotionally but I pretend to comply 00:39:19-2</p>

Appendix 5

Charted Framework

Psychiatrists' understanding of psychosis

Psychiatrists' demography	Doctor patient relationships	Stresses on relationship	Needed characteristics
John, 70, White English	Need for constant learning, mutuality, openness, honesty & empathy 00:43:47-3 My job to provide the right environment so patients can do the emotional work 00:58:22-1	Work is hugely frightening 00:07:36-1 Worry about your own hold on reality slipping 00:07:36-1 Loss of patient's ability to focus makes it hard to follow their thinking 01:02:27-9	One should always have doubt 00:34:17-2 Need to be able to learn from patients 00:43:47-3 Some drs. don't see the patient, they see what they want to due to fear 00:50:25-1
Gita, 40, Indian	Self as healing agent is a new concept 00:32:19-8 Presence & listening reduces need for aggressive treatment 00:43:52-0	In NHS, toss up between qual of life & risk mgt 01:05:22-9 We avoid presence for fear of being drained 00:36:03-7 Really listening feels too much 01:10:45-9	Understanding of self is important 01:21:55-9 Threshold of risk needs to be high but most have need to control everything 00:30:00-8 Openness to new ideas is important 01:10:45-9
Keith, 50, White British	Reduced contact with patients is a loss 00:13:21-1 Job about resolving symptoms, relieve distress, improve functioning, reduce risk 00:33:15-1	Bureaucracy has taken away from passion & satisfaction 00:21:38-9 Acute wards untherapeutic 00:01:32-0 Doctors affected by the stigma of work 00:42:11-0	

Appendix 6

Joint conceptual scaffold from study data

1. Understanding psychosis

Patients- my story matters

How my story helps

What I needed to understand myself

Psychiatrists- important to attend to own psyche

What attending to self and others taught me about psychosis?

What is needed in understanding?

2. Understanding human ontology

What is a good life?

What do we need?

The role of others?

What role does illness play in ontology?

Different ways to understand life

3. Working with human complexity

There are very different paradigms in use

There is an urge to simplify:

- in training

- in understanding humanity

- in understanding psychosis

- patients' needs in treatment

Impact of simplification upon patients and psychiatrists

Appendix 6

Joint conceptual scaffold from study data

4. Significance of relationships

Impact of relationships with patients on psychiatrists

Impact of relationships with other psychiatrists

Patients' relationship needs in treatment

Relationships within the Movement

Using relationships to understand self and others

5. Systems design issues

Psychiatrists- Training impacts

Understanding of self

Understanding of life

Understanding of psychosis

Organisation and delivery of treatment

Parameters and conduct of research

Patients- Systems impact

Understanding of self

Understanding of psychosis

Understanding of life

Understanding the necessity of relationship

Appendix 7

Summary sub-indices in joint conceptual scaffold

Patients on Understanding psychosis	Indicative quotes from	Psychiatrists on Understanding Psychosis	Indicative quotes from
Visions and voices helped cope	Fay, Ann, Ben, Jane	Passion & meaning in psychosis, not just chemistry	All except Keith & Doug
Voices & visions protected me	Nicola, Fay	No meaning in psychosis	Keith & Doug
Voices always there	Keats, Amy, Nicola	All biological, nothing unconscious	Keith & Doug
Voices came when I was stressed	Keats, Amy, Bonnie	A bio-psycho-social existence	All except Doug
Voices - messages I needed to hear	Ann, Keats, Jane, Jenna	Psychology seen as an adjunct, not essential	All
Voices made it difficult to reach out	Fay, Amy, Nicola	Success in treatment is ambiguous	Seth, Keith, Don, John, Dale, Gita
Voices- a sign of internal conflict	Ben, Keats	Not satisfied with current state of knowledge	All except Doug
Voices- linked to abuse/ trauma	Keats, Nicola, Fay, Bonnie	Personhood not addressed	Hans, Dale, Don, John, Seth, Len, Gita, Raj
An inadequately resilient home created problems	Fay, Amy	Hopelessness central to psychosis	All except Keith, Doug, Hans
Problematic families	Bonnie, Jane, Nicola	Not sure we believe or have hope in what we offer	All except Doug
Hopelessness at the core of psychosis	Fay, Amy, Keats		
Ask me my story	Keats, Nicola, Ben		
Schizophrenia- a way of not seeking help	Fay, Amy, Keats, Ben		
Need to be listened to	All		
Need to be believed	All		
Need safe space	All		
Single paradigm not enough	All		

Appendix 7

Summary sub-indices in joint conceptual scaffold

Patients on Understanding ontology	Indicative quotes from	Psychiatrists on Understanding ontology	Indicative quotes from
The need to develop a narrative	Keats, Ben, Fay, Amy, Jane	Attention to self & personhood essential	Seth, Don, John, Hans, Dale, Gita, Raj, Anna
The need for others	All	Deep reasons for choosing profession	Anna, Seth, Don, John, Hans, Dale
The meaning of life	All	A lumpner or a splitter-analysis or synthesis	Dale, Hans, Don
Looking for the flame in the person	Keats, Ben, Nicola, Jane	Integration as a doctor important	Gita, John, Dale, Hans, Don
The need to search within myself	All	Hope is essential to life	All except Keith & Doug
Meaninglessness in psychiatry hampers	Ben, Keats, Fay, Jane, Bonnie	What do patients need?	Don, John, Hans, Len, Dale
Hope essential for the quest	Nicola, Fay, Keats, Ben	Does psychiatry offer us what we need?	Keith, Dale, Len, John, Seth, Don, Gita, Raj
Necessary to attend to sense of self	All	Do patients get what they need?	Keith, Raj, Gita, Don, John, Len
Seeing vitality in others with diagnosis surprised me	Nicola, Amy, Fay, Keats, Jane	Do we know enough?	All except Doug
Wanting to become undead	Jane, Fay, Keats, Ben	Seeking meaning in work	All except Doug
Wishing to understand the pain	Nicola, Amy, Jenna		
Wishing to understand more	All		

Appendix 7

Summary sub-indices in joint conceptual scaffold

Patients on working with human complexity	Indicative quotes from	Psychiatrists on working with human complexity	Indicative quotes from
They use a different language	Fay, Ann, Bonnie, Jenna	Psychosis is inadequately understood	All except Keith & Doug
We live different realities	Nicola, Keats, Ben	There are many selves, many models	Hans, John, Don, Len, Gita
Categorising used to help them manage their anxiety	Fay, Jane	Complexity and uncertainty big part of work	Don, John, Hans, Dale, Anna
Need stories, not drugs	All	Picture of success in psychiatry very mixed	All
Ignoring my experience	Nicola, Keats, Ben, Jane	Once mad, always mad	Keith & Doug
A lack of dialogue	Fay, Amy, Jane, Keats,	Medical practice carries meaning	All except Keith & Doug
Simplifying so much	Jane, Fay, Ben, Amy	Not all think about meaning	Dale, John, Don, Gita, Raj
Only their narrative allowed	Keats, Fay, Ben, Nicola	Pressure to simplify medicine	All except Doug
Psychiatry kills hope	Fay, Jane, Nicola, Keats	We feel impotent in our work	John, Don, Dale, Len, Anna
Psychiatry denies reality	Ben, Fay, Keats, Ann,	Simpler models feel more effective	All except Keith & Doug
Many levels to life, not just one	Jane, Bonnie, Keats, Fay	Our choice of paradigm says a lot about our personality	Dale, Seth, John, Don, Gita, Raj, Anna
Symptoms, not just a pathology	Keats, Nicola, Fay, Amy	Enormous need to retain hope in work	Dale, Don, John, Gita, Raj, Seth
Past is present unless dealt with	Jane, Keats, Nicola, Fay	We don't recognise how our needs lead to compromises in practice	All except Keith & Doug
They don't know everything	All	Mainstream psychiatry is mono-cultural	All except Keith & Doug
Reality changes	Fay, Jane, Ben, Keats, Bonnie, Nicola		
Need a different paradigm	All		

Appendix 7

Summary sub-indices in joint conceptual scaffold

Patients on significance of relationships	Indicative quotes from	Psychiatrists on significance of relationships	Indicative quotes from
Absence of growth due to lack of connection in treatment	Jane, Nicola, Ann, Fay, Bonnie	Relationships attractive	All
Psychosis- a way to deny need for others	Bonnie, Jane, Nicola, Fay, Amy, Keats	Relationship essential	All except Keith & Doug
I wanted to be met	Ann, Bonnie, Nicola, Ben	Different sorts of doctors- fixing vs. relating	Dale, Don, Seth, John, Don, Len
A lack of care and attention	All	Need support for self	All except Doug
I felt unsafe	Bonnie, Fay, Ann, Jane, Ben	There is a fear of empathy	John, Don, Len, Dale, Gita
They ignored my experience	Ben, Nicola, Jane, Fay	Attitude informs model	All except Keith & Doug
I needed fellowship	Bonnie, Ben, Jenna, Keats	Terror and fragility at the core	Len, Don, John, Gita, Raj, Dale
There is a need to take interest	Keats, Ben, Nicola, Jane	Patients and psychiatrists affected by each other	Len, Don, John, Gita, Raj, Dale
Hope comes when taken seriously	Keats, Jenna, Bonnie	Lack of respect and openness	John, Don, Dale, Anna
Recovery needs others	All	Polarisation affects intra-profession relationships	All except Hans, Doug, Keith
Intersubjectivity - we're affected by others	Keats, Fay, Bonnie, Jane, Amy, Nicola, Ben	Defensiveness within profession	Hans, Anna, Don, John, Gita
Importance of being accepted	All	Science prized over relationships	Gita, Hans, Don, John, Dal
Treatment reproduced relational trauma	Keats, Nicola, Fay, Jane	Knowing self essential to knowing others	Don, John, Hans, Gita, Len
SUM made me whole	All	Self development essential	Dale, Gita, Raj, Don, Hans
Power concerns dominated treatment	Keats, Ben, Fay, Ann	Relationship based models offer hope to both sides	All except Keith & Doug
There's a need for trust	All		
Empathy essential	All		
Repeatedly let down	All		
A sense of conflict dominates	All		

Appendix 7

Summary sub-indices in joint conceptual scaffold

Patients on Systems design issues	Indicative quotes from	Psychiatrists on Systems Design Issues	Indicative quotes from
Structures affected self-perception	Fay, Jane, Nicola, Jenna	Training emphasises technology	All except Keith & Doug
Splits in NHS treatment reproduced early trauma	Keats, Fay, Amy, Bonnie	Training de-emphasises relationships	Don, John, Hans, Dale, Gita
Self brought together only in SUM	All	System does not provide for emotional processing	Raj, Seth, Len, Keith, Dale,
Misguided treatment damages	All	Language to describe complexity is lacking	Gita, Seth, Dale, Don, John, Hans, Anna
Too much medication kills vitality	Amy, Ann, Nicola, Keats, Fay, Ben	Objectivity, not connection is valued	Don, John, Hans, Dale
Systems thwart human need to relate	All	Training unfit for purpose	All except Doug
Rendered inactive in my own treatment	Nicola, Bonnie, Amy, Jane, Ben	Insufficient exposure to psychosis in training	Seth, Len, Dale, John, Anna
Doctors not trained to manage uncertainty and anxiety	Amy, Fay, Ben, Jane, Jenna	Systemic devaluing of psychiatry plagues treatment	Don, John, Len, Seth
Risk taking essential but system is risk averse	All	Professional environment - full of fear and risk aversion	All except Keith & Doug
		Let down by the systems	All except Doug
		Systemic priorities different from clinical ones	All except Doug
		“Doing” is prized over “Being”	Don, John, Hans, Gita, Dale
		Psycho-social stuff too complex	All except Doug

Appendix 8

Table 1. Arriving at the core concept of Patients' need for relationships

Relevant indices	Sample of Sub indices	Refined themes	Final themes	Indicative quotes from
<ul style="list-style-type: none"> • My story matters • Need for safety & trust • The need for dialogue 	<ul style="list-style-type: none"> • Psychosis- personal or impersonal? • How was I at the start? • How am I now? • My journey • My memories • Facing the hurt 	<ul style="list-style-type: none"> • Is there anything to understand in psychosis? • Different understandings 	A narrative based on relationships	Fay, Ben, Keats, Nicola, Bonnie, Ann, Jenna, Jane, Amy
<ul style="list-style-type: none"> • Understanding ontology • Working with complexity • Significance of relationships 	<ul style="list-style-type: none"> • Range of experiences • Impact upon me • Understanding life • Becoming aware of my needs • Fear of others • Need for others 	<ul style="list-style-type: none"> • Recognising self • Relationships hurt and heal 	Relationships- a two edged sword	Bonnie, Jenna, Nicola, Keats, Amy, Fay, Ann, Jane
<ul style="list-style-type: none"> • My story matters • Significance of relationships • Understanding psychosis 	<ul style="list-style-type: none"> • Denial of relationships • Relationships in SUM • Who am I? • Psychosis is about relationships • Psychiatry resists relationships 	<ul style="list-style-type: none"> • Negative treatment experiences • Understanding myself 	Using relationships to develop new self	Ben, Keats, Fay, Amy, Nicola, Bonnie, Jenna, Jane, Ann
<ul style="list-style-type: none"> • Comparing treatment experiences • Understanding psychosis 	<ul style="list-style-type: none"> • SUM vs. psychiatric understanding • We're not independent • Psychosis is personal • Need personal attention • Need others to commit to me 	<ul style="list-style-type: none"> • Moving out of indoctrination in the medical model • Intention behind the gaze matters 	Intersubjectivity or how others affect us fundamentally.	Ann, Keats, Fay, Amy, Nicola, Ben, Jane

Appendix 8

Table 2. **Arriving at the core concept of Psychiatrists' need for hope**

Relevant indices	Sample of sub-indices	Refined themes	Final themes	Indicative quotes from
<ul style="list-style-type: none"> Complexities of psychiatry Complexity of psychosis Understanding ontology 	<ul style="list-style-type: none"> What is the job? Difficult feelings force people to simplify Have no feelings So much trauma Such responsibility Such difficult job Not much going on here Lots to process 	<ul style="list-style-type: none"> Simple vs. complex Affected/Unaffected by the work 	Terror & fragility at the core	Hans, John, Don, Len, Dale, Seth, Raj, Gita, Anna, Keith
<ul style="list-style-type: none"> Does training offer enough? Personal factors in professional development 	<ul style="list-style-type: none"> Simple science Complex science Psychosis so very human Negative capability Patients need us to carry hope 	<ul style="list-style-type: none"> A reflection of our ontology Protecting ourselves Patient needs vs. psychiatrists 	Avoiding difficulties to protect self	Seth, John, Len, Dale, Raj, Gita, Doug, Don, Hans
<ul style="list-style-type: none"> What does a person need? Attitude informs model Denying complexity 	<ul style="list-style-type: none"> Need for self-understanding Include patients' subjectivity hopelessness pervades Being with vs. doing to Simple biological dysfunction 	<ul style="list-style-type: none"> Complementarity needed Complexity is emotionally taxing 	Simplification as a life strategy	Doug, Keith, Seth, Don, Len, John, Gita, Raj
<ul style="list-style-type: none"> Inadequate models Defensiveness within profession Prizing science over art 	<ul style="list-style-type: none"> Broad training helps It's all too much Fear is paralysing Systemic distrust and dysfunction Hope essential 	<ul style="list-style-type: none"> Need to feel capable Broader models help 	Psychiatrists are human	Seth, Hans, Don, John, Len, Keith, Doug, Gita, Raj, Dale