

Guardedness in Communications between People Experiencing Acute Psychosis and Mental Health Nurses

**A thesis presented to Dublin City University for the Degree of Doctor of
Philosophy**

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Operational Definitions

Acute Psychosis

The term acute psychosis is commonly used among mental health professionals when referring to the presence of certain experiences that are occurring for a person. Experiences, what clinicians consider hallucinations, delusions, thought disorder and abnormal behaviour, and is believed as central features of the diagnostic terms schizophrenia, bipolar disorder and paranoia. The term also indicates that there is an increased intensity and severity attached to these experiences that leads to families and some who experience these experiences, to seek help from mental health professions.

Service Users/Patients/Clients

Within public mental health services the term patient, client and service user is used interchangeable when referring to those who attend these services and it is noted that they are also used interchangeable in the literature. In terms of clarity those study participants who had experienced acute psychosis are referred to as 'service users' or 'service users experiencing acute psychoses'. Where appropriate other attendees of mental health services that have a different diagnosis, for example depression will be referred to as 'patients'.

Nurse

In the main the term 'nurse' will be used instead of mental health or psychiatric nurse.

Communication

In relation to this study the term communication refer to the process of service users/patients and nurses interacting and conversing with each other.

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Guardedness in Communications between People Experiencing Acute Psychosis and Mental Health Nurses

Abstract

Mental health nurses are the largest cohort of clinicians working in Irish Mental Health services, and are usually involved in the care of service users experiencing acute psychosis either as in-patients, mental health community facilities or in the service users own home. Some service users place value on communication with nurses as it helps with easing their difficulties (Gilbert, Rose and Slade 2008; Russo and Hamilton 2007, however others report not been listened to, ignored and disempowered (Octwell and Capital Members 2007). In addition, both groups worry about risk and vulnerability when communicating with each other (Norwood 2007; Duxbury and Whittington 2005). Consequently, understanding the process of how these two groups manage to communicate together is worthy of study as research into this area is limited. Hence, this Classic Grounded Theory study aimed to address these gaps by developing a substantive theory pertaining to the phenomena of communications between nurses and service users experiencing acute psychosis that could be used to inform mental health nursing practice (Glaser and Strauss 1967). This involved interviewing sixteen participants, seven nurses and nine service users who had experienced acute psychosis, and getting their views about communicating together.

The study led to the development of a substantive theory that explains how they established what constituted permissible communication for period in time through the processes of guardedness in communications. The theory incorporated a dynamic psychosocial process where nurses and service users moved from raising to lowering guardedness and vice versa depending on their sense of risk, attempts to ease distress, or consider that it is advantageous to raise or lower their guard. This was a complex and interactional process which was influenced by past experiences, current events, contexts and how nurses and service users presented when communicating. This guardedness in communications also facilitated a sense of ownership and control over what they say and do. It is proposed that mental health nurses and service users can use appropriate guardedness to establish what they consider are permissible communications at a moment in time, in order to enhance their understandings of how they communicate together and hopefully to make a difference for service users experiencing acute psychosis.

Chapter 1. Introduction: Study Overview

1.1 Introduction

This Classical Grounded Theory (CGT) study (Glaser and Strauss 1967) explored patterns of communications that occurred between mental health nurses and those service users who have experienced experiencing acute psychosis in a mental health service care context in Ireland. A substantive theory was developed that explained the processes by which participants established permissible communications by employing varying degrees of guardedness when communicating with each other. This chapter will provide an overview for the research study. Within this study, the term communication encompasses the processes of communication and interaction.

1.2 Background and Rationale for the Study

Acute psychosis has a significant impact on those who have self-experience of it, their families, mental health services, and the economy (Daly and Walsh 2013; Geekie et al. 2012; Wu et al. 2005; Martens and Addington 2001). The term acute psychosis is commonly used among mental health professionals when referring to the presence of certain experience that are occurring for a person. Experiences that mental health clinicians define as hallucinations, delusions, thought disorder and abnormal behaviour, which are considered a central feature of the diagnostic terms schizophrenia, bipolar disorder and paranoia. The term acute psychosis also indicates that there is an increased intensity and severity attached to these experiences that often leads families and some who experience these difficulties, to seek help from mental health professions. A number of those that speak from experience and/or a position of advocacy for service users would not necessarily disagree with the above, but would take issue with various explanations of causality and treatments offered (Romme and Escher 2012). However, there is also a traditional and growing critique of the dominant understanding of the concept of psychosis, which maintains that psychosis is a meaningless construct that very few clinicians can agree on and has limited usefulness (Bentall 2013; Szasz 1970).

Over a lifetime, about 1% of the population will develop psychoses (NICE 2014). The occurrence rate per year for schizophrenia spectrum is between 0.1 and 0.4 per 1000 population, and a prevalence rate – the total number of cases known to exist, which is often measured over a one year period, is 1-17 per 1000 persons (WHO 1998). In addition, there is

a high economic cost for health services in relation to psychosis. Behan, Kennelly and O'Callaghan (2008), estimated that the economic cost of the psychoses for Ireland in 2006 was 406.6 million euros. The impact that psychosis has is reflected on the Irish psychiatric hospitals/units is brought home through the admission rates of those experiencing psychosis into psychiatric hospitals/units. In 2013, those that were experiencing psychosis comprised of 31% of all admissions; this is compared to an admission rate of 28% with depression, and 16.7 % with neurosis – disorders where anxiety is a central feature (Daly and Walsh 2013). In addition, those experiencing psychosis are six times more likely to be admitted involuntarily when compared to those with depression, and eighteen times more likely than those with neurosis.

The impact of the experience of psychosis on individuals can be extensive, such as feeling confused and vulnerable, experiencing emotional distress, an uncontrolled sense of self and experience upsetting and strange thoughts and/or voices, and feeling frightened (Koivisto et al. 2004). As a consequence, it also impacts on the person's behaviour where others notice them doing unusual or risky activities, for example, isolating themselves from friends and family, being suspicious of others, or having to be rescued by fishermen when swimming an estuary fully clothed in mid-winter (Cockburn and Cockburn 2011). These experiences and behaviours are noticed by families, friends and others in their community leading to concern and worry, which usually leads to help seeking from family doctors and ultimately mental health services. It is within this context of mental health care that service users and nurses begin to communicate together. However, these communications can quickly fluctuate between it being tense, difficult and disempowering to those that are experienced as more relaxed and helpful (Octwell and Capital Members 2007; Koivisto et al. 2004; Bowers et al. 2002). Therefore, this study will explore how service users who are experiencing acute psychosis and nurses manage to communicate together.

1.3 Study Aims, Methodology and Methods

The aim of this Grounded Theory study is to explore patterns of communication with nurses and service users (over 18 years) that had experienced acute psychosis and in contact with a nurse(s) at that time. Its purpose was to develop a substantive theory that could be used to inform mental health nursing practice (Glaser and Strauss 1967). The study employed Classic Grounded Theory methodology as this researcher was attracted to the idea that it allows him to commence by exploring the area of interest without any preconceived ideas about its

outcome (Glaser 1998). It also emphasises letting the problem emerge from the participant's perspective, finding a latent pattern of behaviour and offering a theoretical explanation for the process of guardedness, so as to develop a theory of practice.

1.4 Thesis Outline

This thesis comprises of a further eight chapters. Chapter two provide an overview of different perspectives of psychosis available to nurses and service users experiencing acute psychosis within Irish Mental Health Services, which includes epidemiological data, theoretical perspectives and related practices, and personal person accounts of the experience of psychosis. It also gives an overview of some communication models and approaches available to nurses and some perspectives of nurses and patients of mental health services on their interactions. Chapters three and four provide an outline of the CGT methodology as developed by Barney Glaser and describes how it is applied in this study. Chapters five, six and seven offer a detailed description of the main concern, core category and substantive theory, outlining the psychosocial process in which nurses and service users experiencing acute psychosis engage in developing *guardedness in communications*. Chapter eight places the substantive theory in the wider knowledge domain and explores the main aspects of the theory fit within the literature. Chapter nine, the final chapter, discusses how the substantive theory has implications for clinical practice and education.

1.5 Summary

This introductory chapter provides an overview of the background, aim, purpose and rationale for selecting CGT methodology for this study, and gives a brief outline of the following chapters. It also introduces the substantive theory *Guardedness in Communications between People Experiencing Acute Psychosis and Mental Health Nurses*, which relates to how nurses and service users experiencing acute psychosis establish what constitutes permissible communications between them at a moment in time. The following chapter provides an overview of the literature on the concept of psychosis and in particular understandings and clinical approaches available within Irish Mental Health Services, and a review of literature on service users and nurses' communications.

Chapter 2. Literature Review:

Psychosis and Communications: Main Understandings and Approaches Available to Mental Health Nurses Working in the Irish Mental Health Services

They say I am mad That I am evil And creepy That my genes are corrupted And my brain is deformed That my actions are freaky That my behaviour is not the norm They ask me the question Sir why are you this way?"	I tell them such: "A genetic predisposition An environment unsound The reason for madness Does not matter to me For I believe In the world Of impossibility"
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Dan Hoeweler
Blast Off To Insanity
20 poems about schizophrenia (2014, p. 2)

2.1 Introduction

This chapter provides a comprehensive review of existing knowledge in the field of psychosis studies and communications between service users experiencing acute psychosis and nurses in the context of mental health care settings. An examination of these topics also provides understandings of how they can shape mental health professionals' and service users' perceptions and practices as they interact with each other. In addition, this chapter also outlines various theoretical perspectives on psychosis, communication approaches available to nurses when interacting with service users, and published service users' and nurses' perspectives on how they communicate, thereby setting the context and articulating the rationale for this study.

2.2 Psychosis: A Contested Concept

The term psychosis comes from the Greek *psyche* (mind/soul) and *osis* (abnormal condition), and refers to an abnormal condition of the mind. It was thought that the term was first used in relation to mental ill health by Karl Friedrich Constatt in 1841 as an abbreviation of psychic neurosis. At that time, neurosis referred to any diseases of the nervous system, both physical and mental. His intent was to emphasise the psychic expression of a brain disease (Bürgy 2008). However, over the intervening period the concept of psychosis has been altered, modified and contested.

Currently the terms psychosis/acute psychosis carry different meanings within different contexts. Within mental health services it is considered a major aspect of illnesses that are based in the brain (Tamminga 2009). It is important to note that within psychiatry the term ‘acute psychosis’ is not a formal diagnosis, but is frequently used within mental services, while within the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5 2013) acute psychosis refers to a symptom complex that is considered to include the “presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour, such as gross excitement and over-activity, marked psychomotor retardation, and catatonic behaviour”. Some who have experienced psychosis would agree with this understanding of their experiences; however others and/or their advocates would take issue with the explanation of its causality and the treatments offered (Geekie et al. 2012, Romme and Escher 2012). In addition, there are those who advocate that these ‘symptoms’ are not indicators of a medical illness, but are a result of “contextual factors, such as stress, trauma (inside and beyond the family), poverty, racism, sexism...” (Read, Mosher and Bentall 2004, p.4). Others maintain that psychiatric treatment is often more damaging than helpful, as it is a coercive in its approach due to an unequal power relationship between psychiatrists/mental health nurses and service users (Antipsychiatry Coalition 2015). Another aspect of receiving this interim diagnosis that has psychosis as its central characteristic, is that service users frequently experience stigmatisation and discrimination, as they are often viewed and portrayed by others in their community and through some media outlets in a negative way (Yang et al. 2013; Stout, Villegas and Jennings 2004).

In this section, the prevalence and incidence of the psychoses, how the concept of psychosis has been redefined and contested over time, the medical/psychiatric approach, biopsychosocial approach, psychosocial approaches, subjective perspectives of psychosis, and those critical of psychiatry are reviewed. The articulations of these perspectives are important, as they influence clinicians’ and service users’ approaches to each other when communicating together.

2.2.1 Prevalence and Incidence

In the DSM-5 (2013) the concept of psychosis is seen as an essential diagnostic component of a number of mental health disorders, for example, schizophrenia spectrum and bipolar disorder. With regards to prevalence and incidence of psychosis, over a lifetime, about 1% of the population will develop a psychosis (NICE 2014). The occurrence rate per year for

schizophrenia spectrum is between 0.1 and 0.4 per 1000 population, and the prevalence rate – the total number of cases known to exist, which is often measured over a one year period, is 1-17 per 1000 persons (WHO 1998). According to Cooke (2014) around 500,000 people in the United Kingdom have a diagnosis of a psychosis, and about 10% of the population will experience a auditory hallucination at some point either as a part of psychosis or as a transitory event. In addition, Cooke also noted that there is a major economic cost for health services in relation to psychosis due to its high occurrence relative to its low incidence (number of new cases per year). A report by Wu et al. (2005) estimates that the direct expenditure for psychoses in the United States of America in 2002 was \$62.7 billion. This included direct care - community, inpatient and medication, and indirect care – loss of productivity, unemployment benefits, mortality from suicide, family care-giving, using homeless accommodation and law enforcement. A similar study was carried out in Ireland by Behan, Kennelly and O’Callaghan (2008), which estimated that the economic cost of the psychoses for Ireland in 2006 was 406.6 million euro’s. This highlights that despite the relatively low incidence it has a large economic impact. Another impact that psychosis has is reflected through the admission rates to Irish psychiatric hospitals/units. In 2013, those mental health difficulties where psychosis is considered a central diagnostic criterion comprised 31% of all admissions; this is compared to an admission rate of 28% with depression, and 16.7 % with neurosis – disorders where anxiety is a central feature (Daly and Walsh 2013). In addition, those experiencing psychosis are six times more likely to be admitted involuntarily when compared to those with depression, and eighteen times more likely than those with neurosis. This high involuntary admission rate not only impacts on the service users and their families, but also on nurses, as interacting with and helping these service users can be stressful.

2.2.2 Medical/Psychiatric Perspectives on Psychosis

Throughout the last century and a half the concept of psychosis within psychiatry has referred to different aspects of the experience of mental distress, as psychiatrists attempted to establish scientific diagnostic criteria relevant to the phenomenon. Their assumption was that these endeavours were the first steps in developing a scientific understanding of psychiatric difficulties (Shean 2004).

Initially, from this perspective, psychosis was considered a subset of neurosis and applied both to serious mental health disorders with possible organic causes and those of the soul –

spiritual crisis (Bürky 2008; Beer 1996). However, there was (and is) an ongoing debate within medicine and philosophy regarding the mind-body dualism, where it was argued that the mind and body are two distinct entities (Neeta 2011). Hence, the aetiology of psychosis was initially divided into those of the body and those of the mind. Some of those who were involved in and influenced this debate included a German neurologist Paul Julius Möbius (1853 -1907), who proposed that psychosis be split into two entities; exogenous and endogenous. Exogenous implies that the cause of psychosis comes from external sources; while endogenous means that there is an internal cause. The psychiatrist Emil Kraepelin (1856-1926) further subdivided endogenous psychosis into manic-depressive illness, and dementia praecox (dementia of the young). The latter was seen as irreversible deterioration of mental functioning and incorporated what were considered discrete components of dementia praecox: paranoia, hebephrenia and catatonia (Bentall 2005; Shean 2004).

Eugen Bleuler (1857-1939), a Swiss psychiatrist, also considered endogenous psychosis to have a physical basis. In 1911 he proposed a different name for dementia praecox; schizophrenia. This is derived from the Greek words *skhizein* meaning ‘to split’ and *phrenos* meaning ‘diaphragm, heart, and mind’, which were considered the anatomical seat of soul, cognitive functioning, and the origin of neural diseases by the ancient Greeks (Dolan 2007). He felt that the term dementia praecox was misleading, as its course did not always result in a serious form of mental deterioration (some people recovered), nor did it always develop in adolescence (Lewis, Escalona and Keith 2009). Instead, Bleuler suggested that at the core of these mental health difficulties there was a separation (split) between different psychic functions of personality, thinking, memory, perception and relations with the outer world. As a result, attempts were made to identify those symptoms that would confirm the diagnosis of psychosis, such as loosening of association (thought disorder); ambivalence (having conflicted emotions and views); autism (withdrawal from the social world); and inappropriate affect (displaying emotions which are incongruent to the situation) (Andreasen 1997). A group of psychoses that more obviously had a physical basis were identified and defined as organic psychoses, for example, infections, head injuries and degenerative brain processes. These now fall within the remit of general medicine.

These changes in the meaning of the concept of psychosis were also linked to the change in the concept of neurosis. As already mentioned, psychosis had become linked with serious manifestations of mental health difficulties, while concurrently neurosis was increasingly

associated with psychogenic difficulties. Karl Jaspers (1883-1969), a psychiatrist and philosopher, attempted to bring together the biological and psychological. In this perspective, neurosis referred to those experiences that could be understandable (from the clinician's perspective) as they were seen as meaningful in relation to the person's life story. Psychosis referred to beliefs and behaviours that did not seem linked to what was happening in the person's life, and could not be understood (from a clinician's perspective), but only explained as a result of a biological cause: it was a disease (Ban 2001). This dichotomy of psychosis and neurosis became the foundation for psychiatry ontology – the classification of diseases. Overall, within the psychiatric field the meaning of the term psychosis has changed over the last 150 years or so, where it has moved from a view that it was a result of a moral/spiritual crisis to a view that it was mainly due to biological causes.

'The Society of Biological Psychiatry was founded in 1945 to encourage the study of the biological causes of and treatments for psychiatric disorders. Its continuing purpose is to promote excellence in scientific research and education in fields that investigate the nature, causes, mechanisms, and treatments of disorders of thought, emotion, or behaviour'.

The Society of Biological Psychiatry, Statement of Purpose, (2013, p.1)

The biological perspective is deemed by many to be dominant in psychiatry in particular in relation to the aetiology, diagnosis, and treatment of psychosis (Geekie and Read 2009; Read, Mosher and Bentall 2004; Clarke 1999). This perspective is sometimes referred to as the biomedical model which changes mental health problems/difficulties into mental health disorders (Barker 2009a), where attendees of mental health services are given a diagnosis by displaying various signs and symptoms, and where treatment is based on this diagnosis (Ryrie and Norman 2009).

Biological/Biomedical Understandings of Causation of Psychosis

The biological/biomedical approach understands mental disorders as a biological function of the nervous system, which encompasses a range of biological theories, such as genetics, neurobiology, and the dopamine hypothesis. Its focus is not only on understanding, but also on care from this particular perspective. The following points fall within the biological/biomedical perspective of psychosis and are explored in some detail as many mental health clinicians rely on them when communicating and treating service users who are experiencing a psychosis (Clarke 1999). The topics are: Genetics, Neurobiology, and the Dopamine Hypothesis.

- Genetics

The human genome contains at least 25,000 genes of which 70-80% influence brain structure and functioning (Moldin and Daly 2009). A genome is seen as the total complement of deoxyribonucleic acid (DNA) replicated in a living organism. The assertion is that there are disease susceptibility genes, which are responsible for, or produce a vulnerability to, the development of mental health problems (Mason, State and Moldin 2009), and that these susceptibilities can be inherited (Fears, Mathews and Freimer 2009). As a consequence, it is maintained that the more severe the symptoms, the greater the relevance of genetic factors (McGuffin, Katz and Rutherford 1991). However, it is acknowledged that as yet there has been no reliable association identified between susceptibility genes and psychosis (Shean 2004; Tsuang, Stone and Faraone 2001). As a result, research has begun to focus on the idea of more than one genetic variant (polygenic) acting in concert to cause the expression of psychosis (Hatzimanolis et al. 2013).

Despite the apparent lack of progress, the main arguments used to substantiate that genetic theory is important in the development of a psychosis are drawn from various family, twin and adoption studies. These studies indicate that the closer an individual is related to someone experiencing a psychosis, such as schizophrenia, the more likely they are to also experience psychosis (Gottesman 1991). For example, a study of identical twins indicates that if one twin has schizophrenia there is a 45-50% chance that the other will also develop it, while if a fraternal twin has schizophrenia, the other has only a 15% chance of developing it (Kirkpatrick and Tek 2005). A similar study conducted in the West of Ireland also supported the above findings (Kender et al. 1993). However, most family studies acknowledge that environmental factors are also likely to influence the development of a psychosis.

In addition, there are those who caution against excessively focusing on genetics as the cause of psychosis, as in the past certain societies and groups used genetics to decide what were acceptable and unacceptable qualities people should and should not have, which led to discrimination, racism, and mass murder. One unacceptable quality was psychosis, and other mental health difficulties were seen as genetically transmitted, which was then used as a rationale to sterilise and kill those with serious mental health difficulties (Buck 2007). Hence, Read and Masson (2004) express concern that at some future point this rationale could be used again in the above manner or to at least to discriminate against those with psychoses. They also argue that no genetic test has been developed to confirm the presence of psychosis

and that the genetic perspective is overemphasised (Read and Masson 2004). Hence, it appears that there is some evidence that environmental factors have some influence in the development of what the biomedical approach name as a psychosis, but as yet there is no reliable association regarding the ‘susceptibility genes’ and psychosis.

- Neurobiology

Neurobiological causes of psychosis have been pursued for many years, as it was seen as its likely source considering its severe impact on the person, and the possibility of developing into long term a condition (Shean 2004). With the development of new technologies, such as the Computer-Assisted Tomography (CAT) scan, and Magnetic Resonance Imaging (MRI) over the last thirty years, there has been increased interest in this area of study. To date, research indicates that frontal lobe disturbance is associated with many symptoms of psychosis (Maher and Deldin 2001). Although, as already mentioned, it is recognised that the link between these possible abnormalities and psychotic symptom have not been definitely established and more research needs to be conducted (Shenton and Kubicki 2009). However, Read, Bentall and Fosse (2010) maintain that there is a relationship between adverse childhood events and subsequent psychosis, which is highly influenced by socio-environmental experiences. In other words it is likely that traumatic childhood events can be linked to the development of a psychosis in later life. Hence, it is suggested that adverse environmental factors are the main causality of the development of psychosis.

- The Dopamine Hypotheses

This hypothesis suggests that the symptoms of psychosis are caused by an over activity of the neurotransmitter, predominately dopamine, in the brain. Dopamine is normally produced in the brain and functions as a signalling neurotransmitter in mental, motor, endocrine and autonomic nervous systems (Frisch and Frisch 2006; Carlsson 1987). Similarly to all neurotransmitters, dopamine has both a stimulatory or inhibitory action (Videbeck 2009). When certain dopamine receptors excrete too much dopamine, it is claimed that it leads to psychotic symptoms (Maguire and McDonald 2008). Hence, medications developed to block this over activity would in turn reduce associated psychotic symptoms. However, medications developed on the basis of the dopamine hypotheses and prescribed to manage psychotic symptoms are seen by some to be over-prescribed (Friedman 2012), have poor long term results (Harrow, Jobe and Faull 2014), and can have serious side-effects (Elearzar 2015;

Pluso et al. 2012; Uçok and Gaebel 2008). Therefore, many of those who are prescribed these anti-psychotic medications discontinue using them.

Critics of those who view psychosis as being caused by biological factors and being an illness, claim that this approach objectifies service users, invalidates their personal story, and produces shame and guilt both for the person experiencing psychosis and their family (Breggin 1993). While Bentall (2013) states that schizophrenia is a meaningless construct, as heritability coefficients are misleading, there is overwhelming evidence that environmental factors are causal in severe mental illness, and brain studies do not provide clear evidence of neuro-developmental disorder in psychosis. Therefore, the narrow neuro-developmental approach that is employed in mental health services is damaging to patients. Moncrieff (2014) is concerned that the biological psychiatry approach conceals a dramatic shift in the perception of the impact of anti-psychotic medication on the person, as there is claims that it normalises brain chemistry and it is considered has a positive effect on the ‘disease brain’, and generally ignores serious adverse effects both physical and mental. Therefore, it suggests that on one hand there is growing evidence that points towards the problems and usefulness of the concept of psychosis as portrayed by the biomedical approach; on the other hand despite these critical voices it appears that it has minimal impact on those who adhere to the biomedical perspective.

Classification of Psychosis

In order to be accepted for treatment of mental health difficulties a person needs to be diagnosed with a psychiatric disorder (Barker 2009a). The gift of making psychiatric diagnosis is in the remit of the medical profession, such as psychiatrists and psychiatrists in training (College of Psychiatry of Ireland 2015). However, mental health nurses are required to be familiar with, to discuss and often contribute to decisions about diagnosis, as well as discussing and providing information to service users and their families about diagnoses.

The main classifications systems that are currently in use for mental health difficulties are: the International Classification of Diseases (ICD) published by the World Health Organisation, which has assumed responsibility for its collation and publication since 1948 (www.who.int/whosis/icd10/), and the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association since 1952 (www.psych.org/practice/dsm). Within these classification systems the term psychosis has changed continually, for example, the initial DSM edition (DSM-1 1952), psychosis and

neurosis were presented as overarching terms, where psychosis included bipolar disorder, psychotic depression, schizophrenia, chronic delusional psychosis and paranoia. However, since the DSM-3 (1980) was published psychosis and neuroses have not been used in this manner; instead, different syndromes were developed, where psychosis is presented as a central feature/symptom in a number of these syndromes.

In its most recent edition the DSM-5 (2013) psychosis is seen as a central diagnostic component of what is called “Schizophrenia Spectrum and other Psychotic Disorders” (p.87). This diagnostic criterion includes schizophrenia and other psychotic disorders such as: schizoaffective disorder; delusional disorder; brief psychotic disorder; schizophteniform disorder; substance/medication-induced psychotic disorder; psychotic disorder due to another medical condition; and catatonia. In addition, the ICD-10 also emphasises paranoid schizophrenia, which it maintains is the “commonest type of schizophrenia in most parts of the world” (p.80). However, as the title implies, the term remains a central concept within the above diagnostic criteria; it is considered with psychiatry as a key feature of many serious mental health difficulties. In summary, psychosis is presently seen by these classification systems as a syndrome (a collection of symptoms), which is associated with different psychiatric diagnoses.

However, current psychiatric classification systems are considered by some as too restrictive, as they use a biological lens and base treatment on these diagnoses, thereby excluding other explanations and treatments (Mac Gabhann 2014; Bentall 2005). There are also questions raised about the DSM’s reliability and how it is constructed. Warelw and Holmes (2011) were concerned that the DSM-4-TR (and by extension the DSM-5) was a modern day taxonomy, where all human behaviour is being constructed as a potential problem and is being psychiatrised. They argue that this approach has the potential to lead to a deconstruction of the traditional distinctions between the mentally disordered and the mentally healthy, resulting in increased social control over everyone. Read (2004) maintained that psychiatric diagnoses are scientifically meaningless as they lack connection and consistency. He recommends that a more reliable categorising method be developed that has broad agreement between different health professionals, service user groups and has meaning and usefulness for all concerned.

Nevertheless, despite the above concerns, the DSM-5 and the ICD-10 remain the dominant diagnostic systems used in the Irish Mental Health Services. These diagnostic systems are

not only used to identify the presence of psychosis, but any improvement/disimprovement is judged in the relation to these classification systems (Barker 2009a).

Biological/Biomedical Signs and Symptoms – What is Seen and What is Experienced

The main signs and symptoms psychiatrists and nurses observe for, and ask about, when attempting to reach a diagnosis where psychosis is a central characteristic, or to judge the mental health status of service users who are experiencing psychosis are: distortions in thought content (delusions), unusual perceptions (hallucinations), and disorganisation (language and thought process, and behaviour).

Delusions are considered fixed false beliefs that are not amenable to change in light of conflicting evidence. They are deemed one of the archetypical symptoms of psychosis and are often seen as bizarre and not understandable to mental health professionals and families (DSM-5 2013). Those who have experienced what are considered delusions have reported initially experiencing feelings that something is not quite right or just feeling uncomfortable (Shea 2010). At a later stage, there are varying levels of confusion, and unshared perceptual experiences, such as, hearing voices, seeing visions and paranoia (Dilks, Tasker, and Wren 2010). Rufus May noted:

‘I had experienced sleep deprivation and was very confused holding some grandiose and paranoid beliefs involving espionage and science fiction theories. I perceived the television and radio as having interactive messages for me. I also entertained spiritual beliefs focussing on battles between good and evil and having special powers of communication. My concentration was extremely poor. I was in a high state of vigilance, fear and tension, leading to chest pains’.

(May 2014, Resources, p.1)

These occurrences often lead to feelings of increased confusion and fear (Boyd and Gumley 2007). However, these experiences are not always distressing or frightening as some reported a connection to the wider universe or to a divine presence (Jarosinski 2008). Another aspect that is seen as a component of delusions is paranoia. The DSM-5 states that persons who believe they are being persecuted often feel they are:

‘Being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long term goals’.

DSM-5 (2013, p.90)

Hallucinations involve the sense organs in the human body, are experiences that occur without an external stimulus and are considered not to be under a person's control (DSM-5 2013). The five main sense organs are sight, smell, taste, touch and hearing. According to Forchuk and Jensen (2009) auditory (hearing) hallucinations are the most common hallucinations that mental health nurses encounter. Other hallucinations are: visual (seeing things), which are usually associated with psychosis, illicit drug use or when taking opiates for pain control; tactile (touch) are generally linked with drug withdrawal; and although olfactory (smell) hallucinations are rare, they can also occur with drug induced psychosis. As nurses frequently encounter service users who experience auditory hallucinations and considering that its content is usually included in conversations with other clinicians, this form of hallucination will be reviewed in more detail.

Auditory verbal hallucinations (AVH's) refer to hearing a voice or voices and other sounds, for example music in the absence of other people or technological devices, which is distinct from a person's own thoughts. These voices are sometimes derogatory, distressing, and may provide a running commentary on what the person is doing, and thinking. They can also take the form of commands, criticisms, commenting on life events as they happen, and/or conversations with the voice hearer (DSM-5 2013; Forchuk and Jensen 2009; Nayani and David 1996).

A recent study carried out by Milligan et al. (2013) identified a number of themes that were part of the trajectory of voice hearing experience. The first theme was negative triggers, which refers to negative events pre-voice hearing that they thought contributed to its onset. Once these voices commenced, the rejection phase occurred, which included denial coupled with a hope it would soon go away. The next stage in the process was named as crisis-induced change. This was a difficult period for those experiencing auditory verbal hallucinations as there were positive and negative changes. It was positive in the sense that it prompted help seeking from family, friends or services. However, the change could also be negative, as some voice hearers noted that their positive supportive voices became critical and abusive. Over time, it was noted that voice hearers began to move towards trying to understand their experience, which was facilitated through a process of discovering, adjusting, and trying to cope. This process takes place through a combination of self-experience, reflection, having supportive people and help from mental health services. Finally, voice hearers struggled to develop new understanding of their voices, acknowledge it

was part of them, and recognise the recursive relationship that can exist between the voice hearer and the voices.

However, Romme et al. (2009) is critical of clinicians who adhere to a biomedical approach when attempting to help those with AVH. While both perspectives agree that “voice hearers” (p.7) can struggle to cope with these voices/experiences, Romme and his colleagues consider that it is the problems at its source which service users have found hard to live with. Hence, it is considered a reaction to problems in life rather than a disease, life problems such as repeat traumas and/or emotional neglect. Therefore, seeing AVH as symptom of a disease leads to their life problems not in being addressed. Corstens et al. (2013) supports this approach by recommending on the basis of available evidence that psychological therapies (including, but not limited to cognitive behavioural therapy) be proposed as a treatment of choice for hallucinations. However, they discourage the use of medication, electroconvulsive therapy or transcranial magnetic stimulation.

Disorganisation in the context of psychosis includes thought disorder, bizarre behaviour and inappropriate affect (DSM-5 2013). Disorganised thought disorder (and as a result speech) is defined by what the person says and how they say it. For example, they may move off the topic of conversation, it is difficult to follow their line of reasoning, or their answers may be completely unrelated to a question asked. Hence, for communicative partners, such as nurses, their style of talking seems complex, abstract, or at times concrete. Very rarely speech can be so disorganised it is nearly incomprehensible, and has a profound effect on the service user’s ability to communicate verbally. However, even mild disorganised speech can impact on the individual’s social life, as it can result in isolation and stigmatisation (DSM-5 2013; Tamminga 2009). Grossly disorganised behaviour may come across in different ways, such as, having difficulty performing activities of daily living, for example, displaying poor hygiene, being under nourished, and having difficulty in the organisation and preparation of a meal. In addition, a person might appear agitated or upset or behave in a way that does not seem appropriate to the observer. In extreme cases catatonic behaviour could occur; a decreased reaction to one’s environment, keeping a rigid or inappropriate posture, and/or being non-responsive to verbal and motor stimuli (DSM-5 2013).

Many textbooks from a biological/biomedical perspective caution one to be careful about making a premature diagnosis, as some of the above signs and symptoms can fall within what is seen as the normal range of behaving or thinking. However, if someone presents to a

mental health service with a number of these signs and symptoms, and physical causes are ruled out, the term ‘acute psychosis’ is usually given them as a interim diagnosis. In time, if these signs and symptoms continue, it is likely the service user would receive other diagnoses, such as schizophrenia, schizoaffective disorder, or bipolar affective disorder.

Treatment of Psychosis from a Biological/Biomedical Perspective

Pharmacological interventions for psychosis are seen as the principle line of treatment due to their apparent effectiveness in reducing symptoms (Kane, Stroup and Marder 2009; Shean 2004). These medications are usually referred to as antipsychotics, but are also called neuroleptics and are considered helpful in the suppression of agitation, hallucinations, delusions and thought disorder (Lieberman et al. 2005; Tuma and May 1979). The Royal College of Psychiatrists states:

‘The evidence is very clear that nothing else works as well as antipsychotic medications in the treatment of the more troublesome symptoms of psychotic illnesses’

Antipsychotic Medication (2015, p.1)

This can go some way to explaining why most mental health professionals place such importance on service users taking these medications. As a consequence, they advocate that if a service user discontinues their medication, he/she is very likely to experience a relapse, and jeopardise their chance of recovery (Novick et al. 2010; Nose et al. 2003; Moore, Sellwood and Stirling 2000). An aspect of a nurse’s role is to facilitate service user medication adherence as they are one of the primary contacts regarding its administration and addressing associated issues with service users, such as side-effects, possible benefits and reluctance in taking it (Aldridge 2011; Happel, Manias and Pinikahane 2002). This can lead to difficulties between them if the service user discontinues taking the medication, difficulties such as the dilemma of respecting the service user’s right to choose versus worrying about their risk of becoming more unwell and potentially neglecting the nurse’s obligation to be of help (Munetz et al. 2003). This can result in a nurse trying to persuade the service user to comply if in a community setting or sometimes being involved in enforcing compliance if the service user is an involuntary patient. In these situations Aldridge (2012) suggests that nurses adopt a “harm reduction approach” (p.90), using a partnership approach, helping the service user to come to his or her own decision by weighing up the benefits and risks.

A common difficulty that service users have with antipsychotic medication is the issue of side-effects. These are unwanted and unpleasant effects of taking medication. The frequently experienced side-effects are flattened affect, anhedonia, avolition and weight gain. However, on occasion more serious side-effects can occur, such as muscle spasms of the neck or eye muscles; laryngeal; restlessness; poor concentration; shuffling gait; mask-like face; muscle stiffness; drooling; constipation and sexual dysfunction. These unwanted effects can be very frightening and distressing for service users, and are often cited as the reason why people are non-compliant with pharmacological therapy (The Schizophrenia Commission 2012). Some published comments on service users' experience of psychotropic medication are:

"I was on medication for almost 20 years and it just kept me in a zombie state for that time....I was zonked out....Like imagine if it happened to you – imagine if all your gifts were taken away from you and all the ways you – the things you enjoyed most in life were all taken away from you!"

"I do believe that there is a place when people are in crisis for medication...because dreadful suffering goes on when you are either very high or very low, hearing voices or whatever. There is awful suffering and I don't believe in suffering if you can stop it. But [if medication is over-used] I think it is dangerous."

Report of a Survey for the Mental Health Commission (2006 p.30)

Thus, it is not surprising that Lieberman et al. (2005) found that 74% of people experiencing schizophrenia discontinue treatment with antipsychotic medication within an eighteen month period. When they occur, side-effects are usually managed by psychiatrists and nurses through reducing dosage, adding another medication to counteract the side effect, or prescribing a different antipsychotic medication. In general, a balance is sought between risks and possible benefits. However, it is acknowledged that this treatment alone does not return the service user to pre-psychosis levels, as it is a treatment to manage symptoms, not a cure (Clarke 2008).

Ross and Reed (2004) assert that upon re-examining research which claims antipsychotic medication is more effective than placebo, that this research is flawed on a number of fronts. They maintain that rather than anti-psychotic medication being more effective than placebo, there is equivalence between them. Hence, antipsychotic medication is less effective than claimed. With regards to the idea that if service users discontinue this type of medication they are very likely to experience a psychotic relapse, Harrow and Jobe (2013) found a relapse rate of 25-55% within the first six-ten months. However, after six months the risk of future

relapse becomes quite low; despite not taking antipsychotic medication. One explanation they put forward is that this group of medications causes a medicine generated psychosis in the initial discontinuation period due to “supersensitive dopamine receptors, or the build-up of excess dopamine receptors, or supersensitive psychosis” (p.966). Hence, any psychotic relapses after stopping medication are a result of the person being on it in the first place. In addition, there are indications that there is a decrease in this type of medication usefulness the longer it is taken, with less likelihood of recovery. Commenting on this research, Whitaker (2013) hoped that it would provoke debate within mental health about the use of antipsychotics, as he believes that it needs to be rethought. Yet, despite the above concerns it appears that the use of antipsychotic medication remains central to the treatment of an acute episode of psychosis, where it is used to try and reduce symptom severity and any associated agitation (Kane, Stroup and Marder 2009). However, those who adhere to the biological/biomedical approach do acknowledge that antipsychotics are limited in what they can do for negative psychotic symptoms and in the reduction of cognitive impairment.

In summary, within Irish mental health services the medical/biological approach is considered the main treatment for the psychoses, where from this perspective diagnoses are made and associated treatment(s) is offered. These treatments include prescribing antipsychotic medications, providing in-patient and out-patient treatment, and offering support and advice about mental health issues. In the main, psychiatrists and nurses agree with this approach for service users who are experiencing acute psychosis, in particular the use of antipsychotics despite its drawbacks of possible side-effects and service user objections. Those nurses who are involved in these processes meet with service users more often than other mental health professionals, where they frequently discuss relevant issues with service users and family members, such as medication and diagnosis. These conversations include encouragement and problem solving relating to medication adherence, however on occasion it can result in tension and difficulties between them. In addition, nurse prescribing has been introduced into Irish Mental Health Service (Dreenan et al. 2011), but as yet no research has been carried out on its impact on the nurse-service user relationship. Critics of the biological/biomedical approach maintain that it based on a false premise with no clear evidence to support it, which has resulted in psychiatry becoming involved in social control and an increasing tendency to convert everyday difficulties into mental health disorders. In addition, they highlight the disadvantages of the main treatment offered to ameliorate psychotic symptoms; such as antipsychotic medication and its potential severe

side-effects as well as service users feeling stigmatised, and clinicians not addressing underlying issues and invalidating their personal stories. Hence, while it appears that the biological/biomedical approach has some potential to be helpful, it can also contribute to tension and conflict between nurses and service users. In this researcher's experience it appears that at times the biological/biomedical approach appears to be of help to some service users in decreasing their distressing experiences. However, other service users can also experience it as disempowering and stigmatising, resulting in rejection of this approach, which can lead to tensions and conflict with nurses as they are tasked with ensuring medication compliance.

2.2.3 Biopsychosocial Approaches to Psychosis

This approach was initially proposed by George Engle (1977), to emphasize that biological, psychological (thoughts, emotions, and behaviour), and social (socio-economic, environmental, and cultural) factors, contribute to any illness and disease, and must be taken into account at all times. Within this approach, health and pathways to recovery are also understood as containing these three elements. Over the last twenty years the biopsychosocial approach has gained some popularity within mental health services. For example, it is endorsed by the current Irish Mental Health Service policy document 'A Vision for Change' (2006):

'It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems'.

(p.10)

This approach has served as a guiding principle for treatment decisions (Gabbard and Kay 2001), and a way to teach clinicians about the importance of addressing and examining biological and psychosocial aspects of the person's difficulties (Jones et al. 2004). However, problems have occurred in its implementation as frequently the biological is emphasised over the other aspects (Alvarez et al. 2012). Pilgrim (2002) maintains that the main advantage of this approach is that it allows the various disciplines in mental health services to pragmatically coexist as everyone's contributions are considered equally important. However, he maintains that the biomedical model is a "hardy perennial" (p. 590), which survives and thrives due to the socialisation of the medical profession, resulting in doctors favouring the biomedical model, as biological assumptions permeate psychiatric cultural traditions. Thus, the biomedical approach is likely to remain dominant within the

biopsychosocial approach. A model that fits within this approach is one based on stress-vulnerability which is reviewed as it is commonly applied to persons experiencing psychosis and their families with Irish mental health services.

Stress-Vulnerability Model

The stress-vulnerability model of schizophrenia was initially developed by Zubin and Spring (1977), and later by Nuechterlein and Dawson (1984) as an integrated model to explain its aetiology. This model considers stress as a factor that influences the manifestation of symptoms, while vulnerability refers to a person's predisposition to its expression. Hence, the model integrates multifaceted factors that potentially contribute to the risk, course and outcome (Sheen 2004; Ryrie and Norman 2009). With regards to vulnerability, it is proposed that there are two main types. The first has already been discussed; genetic loading and the neurophysiology of the person. The second type of vulnerability is acquired, both prenatally and throughout one's life journey, for example, adverse childhood experiences, poor coping skills or difficulties forming and maintaining relationships. Two different types of stress are also proposed: ambient and stress produced by life events. The former refers to the general stress that people encounter on a day to day basis, while the latter encompasses life events where stress become severe for varying lengths of time. Stress is considered the trigger event. In summary, Zubin and Spring (1977) conceptualise that the complex interaction between biological, psychological and environmental factors produce psychotic symptoms for some people.

Peter Chadwick (2009), a psychologist and someone who has experienced psychosis, believes that the vulnerability-stress model is a good explanatory model for development, treatment and recovery from psychosis, although he re-names it as the "vulnerability–stress–coping model within a bio–psycho-social-spiritual rationale" (p.x). His hypothesis is that genetic vulnerability is widely distributed in the human population, and occupies many genes (polygenic theory) that generally have a minimal effect; but given certain circumstances (environmental) everyone has the propensity to become psychotic. He considers that experiencing psychosis is part of being human, and it also contributes our imaginative, creative and inventive processes.

However, Geckie and Read (2009) argue that the stress-vulnerability model is not a theoretical model, and that it just comprises of a set of assumptions that those who experience psychosis have the above biological, psychological and social features. This means that a

psychosis can only develop when a person has this genetic vulnerability, which only becomes relevant if certain trigger events occur. So, from their perspective it should be describe as a broad framework/approach that has some clinical relevance. In particular, when trying to help service users and families identify trigger events that appear to make relapse more likely.

An approach that has operationalised the stress-vulnerability model is one based on the idea that high expressed emotion in families can cause relapse of psychosis.

- *High Expressed Emotion*

This focuses on the impact high expressed emotions have on a family member(s) experiencing a psychosis. This idea was initially put forward by Brown and Birley (1968) and Brown et al. (1972), who had a lifelong interest in the relationship between stress and psychiatric disorders. Expressed emotion was the operational construct that structured the design of an assessment tool that measured the relationships between the patient and his or her relatives. It is called the Camberwell Family Interview Schedule (Brown and Rutter 1966). This work was later followed up by Leff (1976) and Leff and Vaughn (1981).

Its central tenet is that expressed emotions like hostility, emotional over-involvement, and critical comments are liable to contribute to relapse. It has been suggested by Norman and Malla (1993) that stress levels of those who experience psychosis/schizophrenia rise quickly, even in response to what appears to be minor stress. As a consequence, it contributes to high relapse rates. In addition, it is recognised that the felt burden on families caring for a relative experiencing psychosis/schizophrenia impacts negatively on communication and coping skills (Burbach, Fadden and Smith 2010; McDonell et al. 2003). This occurs in the context of having to deal with strange behaviour and talk, loss of expected future, interaction with mental health services, and changes in how they relate to their loved one (minding/caring role) (Bruce and Schulz 2001). Therefore, this approach maintains that the service user living in a context in which high expressed emotion is prevalent can result in his or her symptoms associated with psychosis returning.

Over the intervening years this approach has continued to be researched (Pharoah et al. 2010; Kuipers 1994). As a result, the expressed emotion (EE) model has produced a psycho-educational approach for helping families and service users. Its main elements are: education about psychosis/schizophrenia; improving communication within the family; modelling and teaching problem solving skills; and relapse prevention plans, and it has had some success

(Fadden and Smith 2009; Addington et al. 2001; Vaughn 1989). This approach not only addresses the psychological and social aspects of a biopsychosocial model, it also actively promotes adherence to prescribed medication. It has recently been adopted by the Irish Mental Health Division, Health Service Executive (HSE), through their clinical program on early intervention in psychosis. Overall, the intent of this model is to reduce relapse rates by helping families reduce their felt burden through learning to communicate and problem-solve about difficult issues, and it appears to have had some success in this area (Cohen et al. 2013).

In the past, blaming families for relatives' mental health difficulties mainly stemmed from certain family studies carried out between the 1940's and 1960's. These studies maintained that certain communication, attachment and interactional patterns within families (particularly between mothers and sons) resulted in their children developing schizophrenia. A study of note was Fromm-Reichmann (1948), who claimed that those with schizophrenia were distrustful and resentful of others, which mainly stemmed from maternal rejection. She coined the term, schizophrenogenic mother. Another was research carried out by Bateson, Jackson, Haley and Weakland (1956), who claimed that certain prolonged distorted communication patterns between mothers and sons (although they also mention other family members), was likely to result in the son's developing schizophrenia. The main distorted and complex communication pattern was called the double bind. Its essence is that the person who later becomes psychotic finds him/herself receiving conflicting communications (usually a demand or request), where one message negates the other. The bind occurs as they feel that they cannot confront this dilemma, thus cannot address it or escape. Messages can be given explicitly or implicitly, or by tone of voice or body language. Hence, the recipients of these messages become confused in their thinking; psychotic. In the 1970's these theories fell out of favour, as other studies found no evidence to support the idea of a schizophrenogenic mother (Hirsch and Leff 1975). However, during this period the treatment of psychosis moved towards a more exclusively biological approach, which attempted to focus on genetic causal explanations. Thereby, many psycho-educational approaches began to minimise or erase any the families/environmental factors in its anthology (Read and Seymour 2013). In other words, it had no role in its development.

However, a study conducted by Wynne et al. (2006a, 2006b) in Finland with people that were adopted and whose biological mothers had schizophrenia, found that functioning and

communication patterns within the adopted family had at least as large a protective and risk factor as did genetics. According to Martindale (2012), this adds significant weight to the idea that it is a combination of nature and nurture (or gene(s)-environment interaction) that influences the development of psychosis, though he cautions against blaming parents, suggesting instead offering supports to those families at risk, such as focused parenting skill classes and family meetings regarding their particular context.

In summary, the biopsychosocial approach has gained in popularity within the Irish Mental Health Services, in particular since the mental health policy document *A Vision for Change* (2006) was published, which recommended an increase in the number of Allied Health Professionals within Community Mental Health Teams (CMHT's), thereby increasing the possibility of this approach being implemented in mental health services. Its main benefits appear to be helping service users and families manage their communications, increase their problem solving ability, and developing relapse prevention plans in order to contribute to the possibility of recovery. This approach also includes prescribing psychiatric medication and encourages its adherence. However, as previously indicated, criticism of the biopsychosocial approach is that in its application the biomedical strand remains dominant with a resulting mediatisation of problems, hence the psychological and social aspects risks being minimised or ignored. In addition, some feel that psycho-educational approaches are mainly a way to get service users and family members to buy into the biological approach when treating psychosis (Read, Mosher and Bentall 2004). They advocate that social and psychological approaches to understanding and treating psychosis be actively promoted. In other words, it facilitates the promotion of the biological/biomedical approach to diagnosis and recommended treatment as a 'truth' that needs to be adopted by service users and their families in order for the service user to manage his/her experiences and/or recover.

2.2.4 Psychosocial Perspectives for Psychosis

Psychosocial perspectives in the context of Irish Mental Health Services usually include certain forms of psychotherapy or groups/meetings that promote empowering service users', families, as well as community participation. Social and vocational training are also considered helpful in providing support, education, and guidance to people with mental health difficulties (National Alliance on Mental Illness 2014). This section focuses on psychosocial approaches that are underpinned by dialogical and cognitive perspectives. This

is not to say that pharmacological treatments are excluded in the overall service user's care plan, but these perspectives do not specifically rely on them.

Dialogical Approaches

These approaches refer to a particular approach to communication between service users experiencing acute psychosis, families, communities and mental health professionals. It considers that people live in social relations both externally and internally (Seikkula and Arnkil 2006). Hence, a service user's personal network is always present when talking to nurses on a one-to-one basis. These encounters focus on personal and professional networks where communications are open, and where meanings are generated by focusing on listening, responses and being heard. It has been introduced into some Irish Mental Health Services within the last ten years, where clinicians, service users and families/significant others meet to discuss relevant issues. Examples include Trialogue meetings and Open Dialogue.

The Trialogue approach was developed initially in the late 1980's by a service user Dorothea Buck, in conjunction with Dr Thomas Block and Ingeborg Esterer and later refined by Michaela Amering and colleagues in Austria (Amering, Milkus and Steffen 2012; Amering, Harald and Rath 2002), while the Open Dialogue approach was developed in Finland by Jaakko Seikkula and colleagues (Seikkula and Arnkil 2006; Seikkula Alakare and Aaltonen 2001). Both approaches were created to help those experiencing psychosis and their families. Trialogue meetings are group based and not formally attached to mental health services, although traditionally most attendees are service users, relative's of service users' and mental health clinicians. These meetings take place in neutral venues'. Open dialogue meetings are incorporated into mental health services, and usually occur in the service user's home with his/her family and others from their social network. The main intent of both groups is that through dialogue, a mutual language is constructed between all participants, which contribute to increased understandings of each perspective which help in resolving the psychosis.

Those that developed and practice Trialogue and Open Dialogue understand it as an inner and outer language which is a social experience that is constructed by people, and that language, that is, any form of speech, is always a dialogue (Seikkula 2003). Here dialogue is seen as different from the Cartesian account of language and meaning, where language is considered as a self-contained, objective system that mediates between the person and an objective world (Shotter 2010). Shotter claims that the Cartesian perspective attempts to account for life by formulating scientific theories that predict future patterns by explaining past events. For

example, someone showing certain signs and symptoms is likely to receive a provisional label of psychosis, with a prediction that without treatment he/she will probably develop schizophrenia. However, according to Rober (2005), this approach fails to take account of living beings who are “involved in their surroundings , continually tuned in to each other and interact with each other” (p.386), what Shotter names as the spontaneous, expressive-responsiveness of our bodies, “the ‘background glue’ holding us together in our relationships” (2010 p.v). In other words, while the process of creating new understandings is active and somewhat unpredictable (Seikkula 2003); the things people come across and talk about obtain meaning through these interactions, where each interaction is unique to a particular place (context) and to those involved (Seikkula and Arnkil 2006). Therefore, it implies that those with a diagnosis of psychosis can reconstruct the way they understand and talk about their difficulties in a way that is helpful for them. Hence, it is through dialogue that service users, family members and mental health clinicians can construct different understandings of what is occurring for them, which contributes to the service user’s recovery process.

- *Triologue*

This refers to the meeting of three groups; persons who experience severe mental health distress, families and significant others and mental health professionals, with aim to:

‘...facilitate communication about the personal experiences in dealing with psychosis and its consequences’.

(Amering, Hofer and Rath 2002, p.105)

The neutrality of the meeting place is important as it symbolised the equality of all attendees.

The original meetings were called psychosis seminars, and as the name implies they focus on psychosis; its impact on all attendees, sharing information, gaining different understandings, and discussing mental health services practices within the context of mutual respectful dialogue. As one of the original founders of triologue, Buck (2007) had experienced traumatic and inhumane treatment in psychiatric services in Germany over a fifty year period, which included forced sterilisation in 1936 and where her views were not acknowledged or taken into account due to her diagnosis:

‘It [psychiatry] remains devoid of conversation and uses medication also under coercion and restraints, only fighting the symptoms, instead of understanding’.

(p.4)

Her contention is that a service user who is overwhelmed by a psychotic experience wants to be taken seriously and to understand what is happening to them. Therefore, Buck and her colleagues organised meetings that included service users, clinicians and family members in the hope that they would begin to move away from holding on to individual viewpoints and develop mutual understandings.

Triologue meetings also attempt to balance power issues between attendees who are considered as either experts by experience or experts by training, and where every voice is treated equally (Amering, Milkus and Steffen 2012). In addition, meetings are held in neutral venues, with a non-hierarchical structure and facilitated by a rotating moderator; agendas are jointly agreed upon, but with the provision to allow other pertinent issues to be raised. Within meetings, the sharing of experience and developing new understanding of different perspectives provides comprehensive recourses for problem solving. This can contribute to developing different encounters in clinical, problem solving and family settings. With regards to motivation for attending, Bock and Priebe (2005) found that service users were keen to change how mental health services practice care, family members wanted more information and to share their experiences, and clinicians were interested in reflecting on the way they work, in order to help those with psychosis and their families.

The Triologue approach has mainly been used in Ireland as a community development initiative relating to mental health services in the context of changing mental health policy (Vision for Change 2006). There was also a concern that despite the changes, mental health professionals' understanding of, and solutions to, mental health difficulties, remain dominant and somewhat detached from service users and families' perspectives (Mac Gabhann et al. 2010). Its purpose is to create shared conversations about the nature of mental health difficulties and how society responds to them. Mac Gabhann et al. (2012) initiated, helped, and supported the establishment of seven Triologue groups throughout Ireland in 2011, with participants reporting an overwhelmingly positive experience. Some issues discussed at these Triologue meetings were: mental health systems lack of focus on people's emotional, social and psychological needs; mental health services focusing mainly on a medical approach; stigma and discrimination; and education about psychical, emotional and mental wellbeing. Participants felt that Triologue meetings were a useful place to address and overcome the above issues, where people found trust, hope and acceptance in a safe place. In addition, it had the potential to be transformative regarding their perspective on mental health.

- *Open Dialogue*

Open Dialogue was developed as a network based psychotherapeutic approach to acute psychosis (Seikkula 2002; Seikkula, Alakare and Aaltonen 2001; Seikkula 1998; and Seikkula et al. 1995). This refers to a way of treating psychosis by means of network meetings that include multiple participants; service user, his/her family, other important people in their network and clinicians. The focal point of treatment is the family/network. It provides treatment in community based settings, where all staff are trained Family Therapists and provide help to service users and families within twenty four hours of receiving a request for help.

Rather than looking for causes or providing solutions to the crisis, their primary focus is to begin to engender reflective processes between everyone present (Aaltonen, Seikula and Lehtinen 2011). The intent is on building up a dialogue between the participants to create new words, and joint language, not only for the psychotic experiences which does not yet have words, but for all participants. The common language of the family is the starting point. This is how each family, in its own language, has named the problem(s); the treatment team then adapts its language to fit with the family. Problems are seen as social constructs; hence, new social realities can be re-constructed.

According to Seikkula (2002) the treatment team has a number of important functions: to create a space for joint experience where each person speaks in his or her own voice, where space and time is given for everyone to talk and respond, and listening becomes more important than the manner of interviewing (Anderson 1997). This creates a sense of safety or develops what the open dialogue approach names as “a tolerance of uncertainty” within the social network (Seikkula 2008, p.486). Here, the psychotic hallucinations/delusions are accepted as one voice among others.

In addition, everything associated with analysing the problems, planning the treatment and decision making is discussed openly and decided while everyone is present, which includes the decision to commence medication or not. In order to guarantee every voice becoming heard (as this approach considers that there is no one truth) multiple views are sought, and a shared understanding that seems useful is agreed. Within this new implicit shared joint language the psychotic experience begins to exist, which provides opportunities for shared understandings that includes contexts. This process of constructing a shared language creates a ‘scaffolding’ where the service user can reach beyond the psychotic talk and begin to

articulate his/her worries in a way that is understood by others (Seikkula 2002). It is reported that this process has helped to reduce psychotic symptoms, which facilitated 84% of service users to return to an active social life, and employment or education. In addition, the incidence of diagnosable schizophrenia has significantly declined with their service area in Western Lapland (Seikkula, Alakare and Aaltonen 2011).

Some criticism of the open dialogue approach is that some service users might not want to talk openly with other family members if they have experienced abuse in their home, and do not consider their home or hospital a safe place (Edward 2010). Dawson (2015) compares it to the early promise of the therapeutic communities that ultimately did not prove helpful to service users. Also, a question that this researcher has is: while this approach appears very promising can this approach be useful to service users and their families if only a couple of clinicians in a particular service practice it, or does it need the whole service buy in? The mental health service that it was developed in had the resources and service buy in for this approach.

Cognitive Behavioural Approach

This approach has been mainly influenced by the work of Aaron Beck (1975) and Albert Ellis (1962, 1977), who for the most part focused on depression and anxiety difficulties. However, in the late 1980's and early 1990's a growing interest developed in the treatment of schizophrenia from a cognitive behavioural perspective (Haddock and Slade 1996). This approach maintains that how events are interpreted influences how we feel and behave and these interpretations can reinforce unhelpful thinking patterns and behaviour. Hence, in relation to psychosis, delusions and hallucinations are seen as stemming from unhelpful interpretations, which cause inflexible beliefs, emotional distress and inappropriate behaviours. Cognitive behavioural approaches aim to help people reduce their distress and improve their quality of life, by helping them modify certain thought patterns and behaviours (Morrison 2004).

Richard Bentall (2004), a psychologist, has attempted to understand psychosis from a cognitive behavioural perspective. With regards to auditory hallucinations he states that service users have a close relationship with inner speech, and it occurs:

‘When people misattribute their own inner speech to a source that is external or alien to themselves’.

(p.198)

He postulates that a possible explanation is that there are problems at a neuropsychological level (how behaviour and cognitions are influenced by brain structures) where the sources of various stimuli are misinterpreted. With regards to delusions, it is considered that they have meaning and usually relate to where service users see themselves in the social world and/or existential concerns; questioning whether their lives have any meaning, purpose or value. Paranoid delusions are considered from an attributional perspective attempts to protect one's self-esteem against perceived threats, and in the context of an ongoing negative self-schema (how one sees oneself based on experiences, beliefs and behaviour). To avoid the threat to self-esteem those who experience paranoia tend to blame others or circumstances considered outside of their control, thus, reducing self-blame and protecting self-esteem. In relation to the cognitive behavioural approach, it is thought that the above style of thinking (and psychosis) has its origins in early childhood experiences (Udachina and Bentall 2014). However, a study carried out by Cafferkey, Murphy and Shevlin (2014) found that the tendency to blame others was also present among a college population.

The cognitive behavioural approach has gained popularity in the last ten to fifteen years particularly with nurses (French 2009) and is usually referred to as Cognitive Behavioural Therapy (CBT), and CBTp when used to help people experiencing psychosis. Within the last year, the national mental health clinical program for early intervention in psychosis suggests that CBTp forms a central strand. CBTp initially looks at what maintains the problem so that a formulation can be developed jointly with the service user. With regards to delusions, a formulation seeks to provide an understanding of how and why certain beliefs and behaviours are occurring, with a plan to reduce identified distressing or problematic experiences. In conjunction with the service user, delusions are de-stigmatized and put in a context of environmental events, service user vulnerabilities and how symptoms are expressed (Wright et al. 2009), in particular, examining how thoughts are linked to certain triggers and how they developed into strong beliefs. This gives the service user a sense of how his/her worries came about, and implies that change is possible. Other techniques used are looking at evidence for and against the delusion; considering their views from another's perspective, and keeping thought records.

It is not usual to apply CBTp in its entirety with service users in acute psychosis as the ability for introspection is diminished at this point (Bowers et al. 2009). However, some nurses employ some CBTp techniques when interacting with service users: techniques, such as, gently looking for evidence for a particular belief, and helping the service user employ distraction to counteract troublesome voices.

However, Martindale (2012) provides a note of caution regarding CBT (which he maintains is based on short term studies of brief interventions) becoming just another ideology that is attempting to gain dominance in psychiatry, which does not take account of important past events in the service user's life. A recent meta-analysis on the impact of CBT on 3000 people that have a diagnosis of schizophrenia revealed that it only had a small therapeutic effect on positive psychotic symptoms. In addition, it was noted that when researcher assertors became aware that the service user had received CBT the reported improvements increased seven fold (Jauher et al. 2014). Therefore, according to this meta-analysis controlling for bias removes any efficacy. Yet, Tai and Turkington (2009) maintain that current evidence for CBTp indicates that it is an effective therapy for positive and negative symptoms of psychoses. This implies that while CBTp can be useful for service users in reducing their psychotic symptoms caution should be exercised regarding it being a panacea for everyone.

In summary, the psychosocial approaches reviewed appear to offer non-pharmacological treatment for service users who experience psychosis and their families. The dialogical approaches concentrate on the multi-voiced participation where in the process of speaking, listening, responding to what is said and understanding the other position, a spontaneous expressive-responsiveness occurs within the family/group/individuals which make change possible. The Cognitive-Behavioural approach concentrates on one-to-one interaction between a clinician and service user, where a service user's thinking patterns, linked emotions and behaviour associated with unwanted and distressing symptoms of psychosis are modified. The intent is to give the service user skills and tools to manage and hopefully reduce these symptoms. While the above approaches have received a lot of positive feedback from service users, and they fulfil advocates and service user groups' requests to introduce and offer non-pharmacological therapies, it is important to note that both the Dialogue and CBTp approaches are delivered by mental health services employees, so it is quite likely that service users are also offered medication. However, one of the differences between these

psychosocial and the biopsychological approaches is that while medication can be discussed at these meetings, facilitators do not introduce the topic or actively promote it.

2.2.5 Alternative Explanations of the Causality of Psychosis

The following accounts of trauma and spirituality address issues that some who have experienced psychosis deem important while traditionally mental health services have deemed less important, which articulates alternative explanations of causality.

Trauma

Childhood trauma refers to negative life experiences including physical, sexual and emotional abuse as well as neglect which result in difficulties in early and later life. One of these difficulties is adult mental health problems including: anxiety disorders, substance abuse, eating disorders, post-traumatic stress disorder, dissociation and personality disorders (Anda et al. 2006; Chapman et al. 2004). Yet, according to Read (1998) the issue of childhood trauma as factor in the development of psychosis has traditionally been overlooked, where the focus remained on the biogenetic approach. Schäfer and Fisher (2011) postulated that this occurred due a belief that apart from medication, other interventions were not considered useful for psychosis, coupled with some uncertainty as to whether service user accounts can be trusted. However, recent large scale studies found that that someone who experienced childhood abuse was statically more likely to experience psychosis than those who reported no abuse (Janssen et al. 2004); while Whitfield et al. (2005) found that adverse childhood experiences significantly increased the risk of hallucinations occurring in later life. In addition, Romme et al (2012) interviewed over three hundred voice hearers within the last twenty years and found that between 70-80% relate their voices to ongoing, long term serious difficulties that they experience as traumatic. These voice hearers defined their abuse in the following groups: sexual abuse combined with physical; emotional neglect; adolescent problems; high current stress levels; being bullied; and physical abuse (Romme et al. 2009), where all but the high stress levels were experienced in childhood. With regards to causality, Romme and his colleagues found interviewees not only attributed the influence of early traumatic events (which creates a vulnerability), but also high prolonged stress and personally significant events occur before an onset or relapse of psychosis (event(s)). Hence, childhood trauma that continues to impact on the person as an adult can be an important issue in the development of a psychosis.

An expert by experience, Peter Bullimore (2012) believes that his experiences of paranoia were caused by childhood sexual abuse which occurred over an extended period of time. This resulted in him becoming isolated, fearful of the outside world, suffering high anxiety, and paranoid, thinking that others knew what happened to him. In his late teenage years he began to experience what he called 'reassuring voices', however over time they became multiple and abusive when feeling upset or recollecting his own abuse, which further contributed to his paranoia. The trauma and associated psychosis became more severe as an adult, in particular at times of severe stress, which had a serious impact on his mental health, personal relationships, and employment. Unfortunately, his experience of psychiatric care was not positive where he received a diagnosis of chronic schizophrenia and at one point was taking twenty-five tablets a day. Therefore, from his subjective experience he recommends that mental health professionals explore the relationship between psychosis and the person's life story or actual circumstances in life, as people build constructs to keep themselves safe. In addition, they need to explore trigger factors both past (trauma(s)) and present (situations and emotions) with the service user, as it would contribute to understanding the underlying meaning of his/her psychotic experiences and aid recovery.

Hence, as the link between childhood trauma and the development of psychosis has been established, clinicians need to pay attention to the service user's life story, their specific experience and understanding of psychosis as this will help them both in how help is given and received.

Spirituality

Spiritual experiences and psychosis have been linked together throughout recorded history. The hallucinatory and visionary experiences of religious prophets and saints have been an essential aspect of religion for thousands of years (Lukoff 2012). Indeed, it is reported that Socrates, one of the most famous Western philosophers, had experienced an 'inner voice' since childhood that at times advised him, which he believed was Divine in origin. Socrates also walked barefoot, wore old cloths, was unkempt, and was difficult to understand at times (Skodlar and Jørgensen 2013). Skodlar and Jørgensen argue that while Socrates' wisdoms and insights are generally lauded (despite it being likely he could be diagnosed with a schizophrenia spectrum disorder), those who currently have Socrates-like experiences should be given time and space to explore them and learn from them, not only to aid recovery, but because it is possible that their perspective can contain wisdom and understandings of ourselves that others often are unable to reach. However, mental health clinicians usually

consider that the above experiences fall within the realm of psychosis, which needs to be medically treated. Yet, spiritual/religious beliefs can have significant meaning for people, in particular when distressed and suffering. This is often pertinent (but not exclusive) to minority ethnic communities. Thus, given the importance placed on spirituality and religious beliefs, Murphy and Leavey (2014) recommend that mental health clinicians need to establish a dialogue with religious groups where cultural beliefs are shared. In fact, the service user movement in the United Kingdom identifies spirituality as a vital element in enabling people with serious mental health difficulties to rebuild a meaningful life (Ralph 2000). In addition, Koenig et al. (2001) found that religion is associated with positive mental health, where those with mental health difficulties use their spiritual beliefs to improve functioning, reduce isolation and facilitate healing. This implies that automatically placing spiritual experiences and beliefs into the realm of psychosis not only risks alienating the service user's subjective experience, it also negates the possibility of a shared development of understandings about possible pathways to recovery.

Patte Randal (2012) recounted her experiences of spiritual emergencies, psychosis and the process of how she came to make sense of how a Christ-centred spirituality helped her to stop her psychiatric medication and maintain her mental health and emotional equilibrium, despite ongoing stressful life events. In her formative years she grew up in a non-religious family within a background of a Jewish and English Protestant culture, emotionally distant parents, and being sexually abused by a relative. Throughout her late teenage and early twenties Patte began to experience feeling elated, needing little sleep, and believing that she had a significant purpose in life. These experiences alternated with her considering life was meaningless, chaotic and feeling she was living in hell. As a result, was prescribed antipsychotic medication. This occurred in the contexts of witnessing her father's sudden death; having a baby at a young age; being abandoned by her husband; smoking; and attending college. Over a period of time, she began to understand that life has some mystical meaning and purpose, a "a sense of pathway" (p.62) or meaningful coincidences which she had a part to play in. There was also recognition through her medical training that what she had experienced what could be named as a bi-polar disorder, but from her perspective deeming it as 'spiritual emergency' fitted better. As a consequence, the model of recovery she promotes is one that includes bio-socio-psycho-spiritual and cultural aspects. Her wish is that adopting this approach would provide a more hope-inspiring context for understanding mental health crises and avoid stigma and hopelessness.

In summary, paying attention to the service users' subjective spiritual understanding of causality and experiences is important not only for clinicians to develop a connection with service users: these experiences and understandings can significantly contribute to service users and clinicians' development of pathways to understand the meaning of what is occurring for them and how it can aid recovery. It is interesting to note that Eeles, Lowe and Wellman (2003) found that nurses demonstrate a tolerance of ambiguity, an awareness of their own subjective experience, and attempt to have a rounded and holistic view of the service users' beliefs more than other professionals.

Critique of Biomedical Psychiatry

The anti-psychiatry movement provides a platform for the critique of psychiatry and associated disciplines by deconstructing the dominant discourse based on biological/biomedical psychiatry and supporting alternative explanations (Bracken and Thomas 2010; Thomas and Bracken 2004). Within these critical arguments it is maintained that psychosis is a meaningless construct that very few clinicians can agree on (Bentall 2013; Szasz 1970). Foucauldian analysis of mental illness argues that as Western culture became more technological *discipline* became important. This occurred through increased 'supervision and surveillance' in order to produce a compliant population. The aim was to increase production and profitability in the factories, to decrease social unrest, and increase social control (Foucault 1977). The effect of this surveillance is to make the person more self-regulatory through the internalisation of the rules of those in power; as a result it brings validation from others as well as reassurance that one falls within what is considered the norm. This emphasis on discipline with a dominant understanding of what is considered acceptable can be seen in the doctor's office and at nursing stations where internalised political and scientific theories turn people (subjects) into things (objects). Therefore, privileging and normalising certain cultural practices over others can disqualify whole groups of people. An aspect of objectification of people is scientific classification (Foucault 1982), such as the DSM-5 (2013). Hence, people with the power of diagnosis are seen as presenting their ideas as a 'truth', that is, what is normal and abnormal, and accepting the dominant 'truth' disqualifies other alternative stories/local knowledge.

2.2.6 Subjective Experiences of Psychosis

'I was totally separated from myself, not knowing what action I was taking, let alone considering how to "communicate"... I was unaware of myself and my psychiatrist was unaware of me.'

Kean (2009 p.1034)

'To try to understand madness without recognizing, acknowledging and incorporating the subjective aspects of the experience into our understandings is an impossible task, doomed to failure.'

Geekie and Read (2009 p.21)

Facilitating service users who are experiencing psychosis to articulate their subjective understanding has gained importance as it is considered significant in assisting recovery. Therefore, it is deemed essential for clinicians to really understand how service users have made meaning of their lives and the psychotic experiences, so as to help them find the lives they are searching for (Roe and Lysaker 2012). This is also important as traditionally they have felt stigmatised and ignored by mental health services, their own communities and the media (Cain et al. 2014; McDaid 2014): ignored in the sense that their personal stories were not really attended to by clinicians, family or by the print and digital media. Ruscio (2004) and Frank and Frank (1993) state that biomedical psychiatry does not really take account of the meaning attached to personal experiences and social contexts, except to confirm diagnosis and to measure the effectiveness of treatment. In addition, Chadwick (2007) maintains that this approach is likely to create distance between the healer and the sufferer. Hence, articulating self-experience accounts and the social context that it occurs in, is currently believed to aid recovery, and it also facilitates the creation of empathic understandings and connection to the person's life story. Over the last couple of decades an increasing number of first-person accounts have been published in journals, books, and internet forums, which not only address people's experience of psychosis and interactions with mental health service, but also its social consequences for them and their perspective on its causality.

Considering the importance now being placed on helping the service user to articulate his or her personal narrative, the author deemed that the following summaries of four powerful published accounts of the experience of psychosis from the perspective of service users and their families important to articulate. These also speak to the themes of culture, trauma, isolation, spirituality, family/significant others support, loss and hope.

Service User and Family Subjective Accounts

Egan Bidois (2012) recounts being given a diagnosis of psychosis, in the context of: prolonged stress; poor sleep; using marijuana; living away from his community; hearing multiple voices and seeing visions. These experiences, although initially frightening, were understandable from his Maori cultural perspective as “being bothered by unsavoury spiritual visitors” (p.36) and sensory overloading, which he was ill equipped to deal with. Within his family and culture, although worrying, it was not considered as unusual to have these experiences and to speak openly about them. As a consequence, he sought help and advice from local healers, who provided practical help to cope with and manage his difficulties. In addition, it was recommended that he speak to his deceased ancestors and traditional Gods for help regarding these spiritual issues. He acknowledges that his experience also fits the criteria for psychosis, where his visions would be named as visual hallucinations, and beliefs as delusions. Egan maintains that medication and the Western approach was unhelpful and harmful for him, and he withdrew from the mental health service he was attending. He credited his recovery on living in and being supported from within his own family and community. Hence, while his experience of attending a mental health service and taking anti-psychotic medication was negative, he was able to access and receive ongoing support from his Maori culture and family that provided a framework for his recovery.

Annie Rogers (2010) recalls feeling different from others during her childhood and felt that she “was living in a waking dream” most of the time (p.73), resulting in her isolating herself from peers. She also recounts hearing voices coming from book cabinets, radiators and trees and believed that if she could translate these voices (as they were celestial), it would save humanity from destroying itself. At sixteen years of age, Annie was hospitalised after a suicide attempt and received a diagnosis of schizophrenia six months later. She experienced numerous readmissions and was prescribed anti-psychotic medication, which she found unhelpful. However, despite her symptoms she managed (with difficulty) to complete school and college. She credits support from her sister and mother who intervened at times to prevent long term admissions to psychiatric hospitals. In particular, her sister helped her integrate with others and draw her back from a “point that seemed to have no return” (p.76), when Annie appeared lost in her psychosis. This support helped to fuel a determination to recover and after four years she felt well and free of all psychotic symptoms. Hence, from Annie’s account she was at risk of becoming lost to schizophrenia and remaining a long term patient of psychiatric institutions, but for the support and determination of her family through

these difficult times. This determination for Annie to recover encouraged her to keep trying to get better.

Peter Chadwick (2009) spoke about his experience of “getting into psychosis” (p.40). This occurred in the context of a childhood experience of an unpredictable, critical mother who presented the world as an unsupportive place where one can only rely on oneself, not feeling belonging to any one place, and separate from the culture within his community; a ‘not fitting in’. In addition, his difficulties were compounded by a sense of guilt and societal rejection of his sexuality. In time, this led to increasing feelings of being under threat and paranoia, where his thoughts and what he attended to recursively justified this perspective:

‘Snatches of conversation overheard on the street; things said made by newsreaders and DJ’s; headlines on newspapers; out of context comments made by people in the workplace – all these things jolted and jogged me towards a terminus both dreaded and yet longed for it’.
(p.48)

It was during this time that he attempted suicide on a number of occasions. However, over time he recovered and credits his improvement to a number of things. The first was becoming involved and feeling supported by others interested in nineteenth century writings, which produced a sense of belonging where he could display his true self. In addition, he sought professional help. This help consisted of: anti-psychotic medication, which he felt helped to remove barriers that were preventing him from being who he wanted to be; group therapy, which helped with becoming more at ease with himself; and attending a day hospital, which assisted in re-socialisation. Hence, Peter’s childhood experiences and sexuality resulted in a sense of isolation, feeling rejected and disconnected from family and society, which ultimately led to psychosis. His pathway to recovery involved finding people/groups he could connect with, and accessing services and treatment provided by mental health services.

Patrick and Henry Cockburn (2011) wrote as a father and son about Henry’s psychosis and its impact on their family. Patrick first learned that his twenty year old son Henry had mental health difficulties when he nearly drowned trying to swim a river estuary near his college in the depths of winter, after which he was detained in a psychiatric hospital. In hindsight, Henry’s mother Jan noticed an “accumulation of many small but bizarre things that he did and said” (p.8) in the weeks prior to his hospitalisation. These bizarre things included: walking around Brighton dishevelled and barefoot; climbing a very high wall which resulted in being arrested by the police; his student accommodation being extremely untidy;

dismantling his mobile phone; and behaving oddly when visiting him. During his time in hospital he received a provisional diagnosis of schizophrenia.

Henry viewed the events of that day when he attempted to swim the estuary somewhat differently. He had decided to walk to Tibet barefoot, so needed to harden his feet for the journey. The morning he left college and went for a walk barefooted along the seafront, where he felt that he was being directed where to go:

'I felt brambles, trees and wild animals all urging me on. It was as if they were looking at me and I could feel what they thought'.

(p.31)

During this journey he ascribed meaning from the environment in a particular way, for example, he saw a 'D' painted on the road and thought it stood for daemon so ran away. He then became convinced people were following him and went into the river where he was later rescued. At that time, Henry did not believe that he had mental health difficulties, but experiencing a spiritual awakening, and that visions were a part of this experience; "I saw a golden Buddha in the sky" (p.38). Hence, he was generally non-compliant with offered treatment and made numerous attempts to abscond from hospitals.

Over the intervening six years there were frequent hospitalisations, which both he and his family found very difficult. His parents lived in constant fear that he might die, as he often placed himself in risky and dangerous situations upon being released from hospital. Concurrently, Patrick became immersed in researching schizophrenia and all possible causes and treatments. He believed that the stress-vulnerability model fitted for Henry as some of his relatives had mental health difficulties and Henry had smoked a lot of cannabis as a teenager. Overall, Patrick and Jan felt frustrated and disappointed with the lack of apparent progress, as Henry appeared to become increasingly lost to psychosis. Their life seemed to consist of "coping with the seemingly endless crisis" (p.209).

Their first sense of any improvement occurred when Henry was admitted involuntarily to a particular hospital and the psychiatrist insisted that staff ensure that he took his anti-psychotic medication. This resulted in improvements to his mental health over a two year period, where he gradually started becoming more independent with the help of his family and mental health services. As part of his recovery his father suggested that they would write a book together about the impact of schizophrenia. Henry acknowledged these improvements:

'It has been a very long road for me, but I think I'm entering the final straight. There is a tree I sit under in Lewisham which speaks to me and gives me hope'.

(p.222)

Hence, the experience of Henry and his family was one that nearly overwhelmed them. Henry was unhappy about hospitalisations and medication, while his family were at an increasing loss regarding how to help him and were fearful for his safety. Yet, his parents did not give up on hope and kept offering their support. In the end, ensuring medication compliance made some positive differences that allowed Henry to leave hospital and live in supported accommodation.

In summary, these first person accounts from service users and family members speak to a variety of experiences not only in relation to psychosis, but also the impact of interacting with mental health clinicians. Some found the biopsychological approach within mental health services useful, while others rejected the help offered, mainly due to beliefs that they do not have mental health difficulties, or to avoid unwanted effects of medication. However, all benefitted from the support and advocacy of caring determined family/significant others. The purpose of articulating the above accounts is to highlight the lived experience and struggles of those who experience psychosis and their families.

2.2.7 Psychosis – Voluntary Support Organisations

Over the last number of decades there has been a growth of voluntary support groups for people with mental health difficulties. The structure for these organisations varies as some were developed by those with experience of mental health difficulties, those who are mental health clinicians, or a combination of both. The main voluntary organisations in Ireland that include people with psychosis are *Shine: Supporting People Affected by Mental Ill Health*, and *GROW: World Community Mental Health Movement*. However, *Hearing Voices Ireland* is a peer support organisation specifically for those who experience hallucinations and other unusual experiences, and is part of an international organisation called the 'hearing voices movement'. These organisations are places where people can share their subjective experience of psychosis and associated struggles and hopes with their peers.

Hearing Voices Movement

The Hearing Voices Movement (HVM) is for those who hear voices when no one else is present. It also includes other unusual perceptual experiences, and is open to their families and mental health professionals. It promotes an alternative view of hallucinations where

voices are not necessarily seen as signs of mental illness, but as a meaningful human experience (Corstens et al. 2014). The HVM was begun in the Netherlands in 1987 by Marius Romme (psychiatrist), Sandra Escher (researcher) and Patsy Hage (voice hearer). Since then it has inspired the development of an international social movement, which is currently called Intervoice. It describes itself as having:

'A close and respectful partnership between voice hearers – who are experts by experience, their carers and mental health workers, academics and activists – who are experts by profession'.

(Intervoice, 2004, p.1)

Intervoice provides a central link, guidance, support, and online resources for national HVM organisations. Its aims are to: show that voice hearing is a human experience; emphasize that the main issue is being unable to cope with voices; educate to reduce ignorance and anxiety about voice hearing; show that there is a extensive variety of voice hearing experience and how people cope; promote the establishment of peer support groups in different countries; and to develop non-medical ways of helping people to cope with voices. One of the organizations linked with Intervoice is the Hearing Voice Network, which has being established in twenty nine countries so far, including Ireland (Hearing Voices Ireland 2014). These groups provide a safe space for people to share their experience and support one another, where attendees can begin to gain some control over their lives through learning to live with their hallucinatory experiences. The provision of a safe place to talk about their experience is considered important as many with psychosis reported experience and stigmatization (Cain et al. 2014). In addition, different explanations for unusual perceptual experiences are accepted and valued, and can be understood in terms of life events and interpersonal relationships (Corstens et al. 2014). There is also a space made available for social outlets as many with a diagnosis of psychosis/schizophrenia feel isolated from others (Dillon and Hornstein 2013). Overall, hearing voices network meetings offer an alternative to the traditional psychiatric perspective to hallucinations and its associated treatment, which some voice hearers find helpful.

In summary, articulating and hearing the subjective experience of psychosis is now seen as not only important for the service users and their families so they can either begin to or further enhance their understandings of what is occurring, but also to develop clinicians' understandings of the service user's life story, as it can lead to a joint identification of those

issues that need to be addressed in order to contribute to the service user's journey of managing or dissolving the distress, fear and psychic pain that is often associated with psychotic experiences. Thus, the inclusion or exclusion of the subjective experience within a clinician's frame of reference impacts on his or her approach when trying to help those in acute psychosis. Those who advocate that time and space should be given to actively ascertaining first person accounts believe that it is not enough just to describe the experience, it is also necessary to look at context, how it is perceived, interpreted and dealt with (Roe and Lysker 2012). Hence, it is considered that enabling and engaging with personal narratives can aid recovery.

2.2.8 Lay Understandings of Psychosis

Lay understandings of psychosis refer to the understandings of those who have little or no direct contact with people who are expert by experience of psychosis. It is important to include this perspective as the opinion of lay people is vital: service users live among communities, and are aware of, and often absorb the opinions of the general public regarding psychosis (Geekie and Read 2009). These lay understandings and opinions often include prejudicial and discriminatory attitudes towards those who have a mental health diagnosis (Mac Gabhann et al. 2010). This research study commissioned by Amnesty International Ireland also found that service users of Irish Mental Health Services felt that they were treated unfairly across all aspects of their lives by, among others, neighbors; friends; work colleagues; family and mental health professionals; in housing; education; and welfare. Overall, their experience was of the general public having negative attitudes towards those with mental health difficulties. Hence, they are likely to live isolated, marginalized lives within communities (McDaid 2014), which can in turn impact on how service users and their families engage with mental health services. The most common fears that lay people have regarding those with a diagnosis of schizophrenia are dangerousness and unpredictability (Taylor 2008; Read and Harre 2001), despite evidence that the vast majority of those who experience psychosis are non-violent or likely to be victims of violence (Babbington et al. 2004; Mullen 1997). Although, a report on suicide and homicides committed in England and Wales noted while the risk to the public is small, 5% of homicides are committed by those with a diagnosis of schizophrenia (National Confidential Inquiry 2006). This overall negative perception regarding those with a diagnosis of a psychosis comes from a number of sources including media coverage. In particular, tabloid media linking psychosis/schizophrenia to violence increases negative attitudes in the wider public towards those who have such

diagnoses (Cain et al. 2014). However, Geekie and Read (2009) also blame those mental health professionals who strongly promote the stance that schizophrenia is a debilitating disease that is mainly caused by biochemical imbalances, and needs to be managed and treated, thereby contributing to the notion of dangerousness. On the other hand, they see hope in the majority of lay public understanding of the causes of schizophrenia, which is based on psychosocial reasons, and the belief that recovery is possible. However, there is widespread negative perception within the general public regarding those mental health difficulties, and in particular people with a diagnosis of psychosis or schizophrenia. This in turn contributes to the felt burden of service users and their families. Therefore, it is important that public hear or have access to subjective accounts of those who experience psychosis, in order to increase their understanding of what service users are struggling with, pathways to recovery, and what lay people could do that might be of help.

2.2.9 Summary of Psychosis: A Contested Concept

This first section of the literature review chapter contextualised pertinent issues relating to the concept of psychosis, such as the biological/biomedical, biopsychosocial, dialogical, cognitive-behavioural, alternative explanations of the causality of psychosis, critique of biomedical psychiatry, subjective experiences of psychosis – both service user and family, voluntary and self-help support organisations and lay understandings. This included how the concept of psychosis has changed, and been redefined and challenged over time.

Within mental health services in Ireland the concept of psychosis is mainly defined by the dominant biological/biomedical approach which considers it as a central feature of the most serious forms of mental health disorders, for example schizophrenia, schizoaffective disorder, and bipolar disorder. Most who experience an acute psychotic episode attend mental health services either in a voluntary or involuntary capacity. It is in this context that they meet and communicate with nurses. One of the processes of attending a mental health service involves being given an interim ‘diagnosis’, such as acute psychosis. This ‘diagnosis’ is made when a person reports and is seen to experience what are considered by psychiatrists as signs and symptoms of psychosis. Another process is being prescribed anti-psychotic medication. Service user subjective experience of psychosis often includes hearing critical and derogatory voices; being hyper-vigilant and feeling under constant threat; feeling tormented; loss of control of their senses of self, and at times believing they have a divine or cosmic purpose and act accordingly. At the same time, their family members and significant others often

experience worry and uncertainty about how to be of help, and feel frightened, stressed and burdened. Nurses can also experience stress and burnout when dealing with tense and difficult situations, for example caring for those experiencing psychosis (McGowan 2001). In addition, the psychoses have a high economic cost on a society. Hence, the impact of psychosis on service users, their families, mental health services and communities is significant.

Help offered to those who experience psychosis is based on particular and sometimes mutually exclusive understandings of the nature of psychosis and associated treatments or approaches. The biological/biomedical approach considers it a disorder of the brain that is triggered by genetic, neurobiological and environmental factors and offers treatment based in this perspective, such as pharmacological interventions, hospitalisation or home support, and psycho-education. A potential advantage of this approach is that mental health clinicians are familiar with it and provides clear clinical pathways for treatment. In addition, some service users agree with this approach. However, other service users, their advocates, commentators and some clinicians have expressed dissatisfaction when the biological/biomedical model, in particular when it is presented as the sole treatment option. Furthermore, many service users choose to disengage with this treatment, mainly due to the unwanted effects of medication, not believing the assertion that they are unwell, or because of worries about stigmatisation. However, others question the validity of the concept of psychosis, as they claim neither consistent brain abnormalities nor specific genes have yet been identified, and there is no convincing evidence that antipsychotic medication significantly impacts on the brain biochemistry. While there is growing evidence that childhood trauma and adverse life events can cause unusual experiences that are difficult to understand, where service users need help is with problems of living and addressing past traumas rather than medication.

Another understanding of psychosis is the biopsychological approach, which promotes understanding and treating psychosis from three perspectives; biomedical, psychological and social. Hence, offered treatment includes pharmacological, individual therapy/support/interventions and family meetings, and support to reintegrate into the community. However, even within this approach it appears that the biological/biomedical approach remains dominant, in particular in the initial phase of services user interactions with mental health services. On the other hand, the dialogical and cognitive-behavioural appear to offer alternative non-pharmacological treatments that significantly include the service user

and families (dialogue and triologue). However, there is also a growing importance on hearing and understanding the service user's subjective experience of psychosis, its impact and its causality such as trauma, and recovery pathways, as well as the development of various voluntary organisations and self-help groups where they feel more accepted and empowered.

With regards to this researcher's understanding of the concept of psychosis, from his experience as a nurse and family therapist both in the past and currently, he contends that mental health clinicians who only adhere to a strict biomedical treatment approach risk it having a negative impact on service users experiencing acute psychosis, such as being disempowered and stigmatised at a time when they feel very vulnerable. However, it appears that all approaches have something to offer the service user to manage and overcome their difficulties as long as they are practised in way that is helpful, empowering and useful. This is similar to Rorty's (1982) pragmatism viewpoint. He would probably say something like; 'It appears to be true that these treatments can be helpful for some people in psychosis', as we have a cherished story about their helpfulness. So, when people engage in these treatments it seems that they have less psychotic experiences and it is seen as useful thing to do in our culture.

2.3 Communication between Nurses and Service Users

'Psychiatric nursing practices are primarily verbal'.

(Peplau, 1987, p.275)

'You meet some lovely nurses but you are also going to meet people who are putting their day in...that is all they are doing.' (Service User)

(Dunne, 2006, p.37)

'No matter how hard one may try, one cannot, not communicate'.

(Watzlawick, 1967, p.48)

2.3.1 Introduction

The main focus of this section of the literature review is to examine prior research on communications and interactions between nurses and service users, discuss core communication theories and practices that influence nurses and service users when communicating together and relevant research in this area.

2.3.2 Nurses and the Therapeutic Relationship

A central tenet of mental health nursing is developing therapeutic relationships with service users that they have considerable contact with. Therefore, there is an expectation that each nurse develop effective interpersonal and communication skills (Clark 2012; Morrissey and Callaghan 2011; Burnard 2003). These therapeutic communication skills are deemed fundamental in the development of positive nurse-service user relationships (Peplau 1987), which is seen as the basis of all nursing intervention (Reynolds 2009; Hem and Heggen 2004), and ensures that their communications have a purpose (Videbeck 2009). According to Barker (2000c) the intent of these interactions needs to be to help patients explore ways to grow, explore how they live and hopefully move beyond their problems of living. Therefore, the main purpose of communication from a nursing perspective is considered to be to provide help to service users to manage and/or overcome their difficulties, through one-to-one contact, and by working within a plan of care that has been developed in conjunction with the service user.

The idea of nurses developing therapeutic relationships with patients was initially promoted by Hildegard Peplau's seminal publication *Interpersonal Relations in Nursing* (1952), which maintained that nursing is an interpersonal process between the nurse and patient. This process is both therapeutic and educational, and can offer opportunities for growth and wellbeing. She also advocated that forming a therapeutic interpersonal relationship with a patient was the crux of nursing, meaning that it is a main or central feature (Peplau 1966). Joyce Travelbee's *Intervention in Psychiatric Nursing* (1969) also advocated that the concept of the therapeutic nurse-patient relationship/alliance was central to the practice of psychiatric nursing and an important variable in patients' health outcomes. These assertions are repeated in the vast majority of mental health nursing text books over the past forty decades (Welch 2005).

2.3.3 Communication Challenges

Despite the claim that developing therapeutic relationships is important, it has been difficult to define and operationalise (Clarke 2012). To try and clarify this issue Dziopa and Ahern (2008) developed a typology of the therapeutic relationship components. They divided it into nine main constructs: conveying understanding and empathy; accepting individuality; providing support, being there/being available, being genuine, promoting equality, demonstrating respect, trust, maintaining clear boundaries and having self awareness. While

Chambers (2005) emphasises the importance of trust, respect, empathy, and power issues. Although, recently in mental health there has been somewhat of a shift in focus to more recovery, equality and collaborative practices (Higgins and McBennett 2007).

Reviewing how service users experiencing acute psychosis and nurses communicate is deemed important as nurses are by far the largest professional group employed in Irish Mental Health Services, and therefore have more opportunities for them and other professionals to communicate with service users. At present there are about 5000 registered mental health nurses working in Ireland (Nursing and Midwifery Board of Ireland 2015). For example, nurses are present on in-patient units/wards twenty-four hours a day, and are very likely to visit these service users in their homes or meet them in mental health day hospitals. Therefore, how they communicate together has meaning and implications for both parties.

Service users place value on how mental health clinicians communicate and interact with them, in particular listening, talking and spending time with them (Gilbert, Rose and Slade 2008; Russo and Hamilton 2007), and appreciate when nurses help them ease their distress (Hem, Heggen and Ruyter 2008). Yet, other studies indicate that often both nurses and service users are unhappy or frustrated about their communications and interactions (Hem 2008; Koekoek, Van Meijel and Hutschemaekers 2006; Duxbury 2002; Breeze and Repper 1998). Therefore, service users and nurses experience of communicating together will be explored from both perspectives in this study.

Peplau (1992) maintains that the purpose of the therapeutic relationship between the nurse and the patient is to investigate and gain familiarity with the patient's understanding of his/her situation and background, and to contribute to strengthening his/her self-esteem, identity, and ability to bond with others, so as to overcome their difficulties. However, In relation to service users experiencing acute psychosis O'Brien and Cole (2003) claim that nurses often experience it as challenging, as some can be withdrawn when they are focused on their internal experiences or frequently seek contact when angry, very anxious or afraid, as well as needing assistance with sleeping, food, and hygiene. Occasionally, service users can also become verbally and physically aggressive towards nurses especially on inpatient units (Duxbury 2008, 2002).

Dual Role – Custodian and Helper

Another identified challenging aspect of nursing care that can cause tension and problems is when nurses try to develop therapeutic relationships with service users in the context of having a dual role as a helper and custodian when working on in-patient units. Deacon (2003, p.466) points to the conflict between “therapeutic nursing” and “custodial nursing”, as those working on wards/units are strongly occupied with various safety measures, like confiscation of patients’ belongings, searching patients, use of personal alarms, locking doors and regulating the patients’ activities so as to minimise risk to self and others (Bowers et al. 2002). So, an aspect of mental health nursing in this context is to monitor and enforce rules in order to set limits on in-patients’ behaviour, such as smoking, sexual appropriateness and aggressive behaviour (Alexander and Bowers 2004). Indeed, a report by the Department of Health and Children (2003) found that mental health nurses are at risk of being assaulted especially when working on an inpatient unit.

The intent of risk management from a nursing perspective is to create a safe environment against violence, aggression and self-harm (Risk Management in Mental Health Services 2011). For nurses, minimising risk and connecting with service users experiencing acute psychosis are important; yet it appears that the reduction and management of risk is considered paramount. This could be due to the various models of therapeutic relationships that nurses learn as students, as Bowers et al. (2009) maintains that these models were not designed for work with acutely disturbed people on in-patient units, and where Horsfall, Cleary and Hunt (2010) assert that chaos and danger have the potential to occur at any time. In addition to the unpredictable nature of an acute in-patient unit, it is also what nurses consider to be the unpredictable behaviour of those with acute psychosis, in particular when they respond to what is occurring for them internally, which nurses consider as delusional beliefs/paranoia/hallucinations (that nurses are unaware of). Thus, nurses are conscious of potential risks when communicating together, and often judge it safer to adhere to risk management procedures rather than focusing on developing a therapeutic relationship.

Risk and Vulnerability

Those who experience psychosis and attend mental health services can have different experiences of care. As discussed in the previous section the subjective experience of psychosis and its impact can be very difficult for service users and their families/significant others. Those who experience acute psychosis report, at times, that they have an

uncontrollable sense of self of varying degrees which includes feeling different, emotionally distressed, vulnerable and insecure, losing confidence in their judgement of others, leading to isolation and shame, as well as confusion about upsetting thoughts. This sense of loss of control can include causing harm to self or others, being controlled by outside powers, which can cause feelings of anxiety, distress, sleeplessness, anger and irritability (Koivisto et al. 2003), and are present when they interact and try and communicate with nurses. On these occasions they believe it is important that they are listened to, taken seriously, reassured and have skilled help to respond to these acute moments so things will not get worse (Living with Psychosis 2012).

With regards to the causality of aggression, a disparity was found by Duxbury and Whittington (2005) between service users and nurses' views about the causes of service user aggression on in-patient units. Service users perceived poor communication and environmental conditions as significant issues for causing aggression, while nurses considered the service users' mental illness to be the main reason. Another factor to be taken into account is the subjective experience of what some service users consider aggression from nurses, such as being restrained when attempting to abscond. "I was rugby tackled from behind by a six foot something male nurse", reported one, while another service user recalled:

'I refused medication and I was held down and injected by six staff. What I really feel strongly about is that no one gave me a choice'

(Octwell and Capital Members 2007 p.49).

These experiences of nurses enforcing hospital policy regarding keeping people deemed at risk to others or themselves in hospital, and ensuring medication compliance, can be quite traumatic for the service user. In addition, the above can occur in the context of feeling frightened, confused, experiencing strange phenomena, believing they were detained unnecessarily and powerless to change their circumstances. Within the above circumstances service users can become resistive and aggressive (Chambers et al. 2014). Other service users can develop negative perceptions of ward/in-patient unit regimes when they feel oppressed by the amount of control over their activities, and/or when rules are applied in a rigid manner, which in itself can lead to aggression (Nijman et al. 1997). Specific communication difficulties identified by some service users result in feeling disrespected as human beings, not being included in their own care, or care that has no meaning in the context of their lives; or feeling that nurses consider them inferior human beings (Olofsson and Jacobsson 2001). In

particular, service users fear and/or experience the loss of the ability to make choices and the authority to implement them (Waters and Cashin 2009), in addition to their creditability being challenged by mental health workers (Lakeman et al. 2012). This sense of loss of personal agency often occurs in the context of forced hospitalisation and being medicated, which usually happens after refusing to engage in offered treatment.

The role of nurses in ensuring psychotropic medication compliance is another potential point of tension between nurses and service users. Nurses play a pivotal role in the co-ordination of medication compliance for service users both in the community and in-patient services. At a ward/in-patient unit level it involves making certain that there are adequate supplies of medication and administering medication, in addition to ensuring its compliance. In community settings nurses are often involved in psycho-education with service users and their families about pharmaceutical services relating to mental health, problem solving as well as encouraging compliance (Duxbury et al. 2010; Cowman, Farrelly and Gilheaney 1997). The report 'A Vision for Psychiatric/Mental Health Nursing in Ireland' (Cusack and Killoury 2012) found that 94% of nurses were involved in medication management, 77% felt it important aspect of care planning, and 88% believed that administering medication was an extremely/very important aspect of the effective delivery of care. Hence, compliance with antipsychotic medication is considered important by most nurses in managing symptoms and reducing relapse rates and hospitalisations for those who experience psychosis (Monahan, Doyle and Keogh 2008). This is considered necessary as service users are deemed to have the potential to develop a chronic and debilitating illness, in particular if they refuse to take medication due to a lack of a significant degree of insight or acceptance of their illness (McPhilips and Sensky 1998). Thus, this strong emphasis on compliance places the nurse in a position of persuasion and control, particularly on inpatient units.

However, with regard to service users who live in the community, it appears that nurses' engagement with them around compliance relies more on negotiation (Henderson et al. 2008). For example, Deering (2004) conducted a study on how nurses can influence service users to adhere to prescribed treatments. She found that developing therapeutic relationships was essential where the nurse and service user can connect on a human level by getting to know each other and trust the other's opinion. This approach allows the nurse to respectfully suggest and work with service users about any issue he/she has about aspects of treatment

plans. However, the majority of nurses believe that medication is an important aspect of managing, treating and hopefully recovering from psychosis, and advocate for its compliance.

Some service user's report that the experience of taking antipsychotic medication is the cause of a worsening of their symptoms in conjunction with the absence of an exploration into their current personal or environmental difficulties or distress (Lilja and Hellzén 2008). Other side-effects can occur when they are prescribed a combination of anti-psychotic medication which has a negative impact on their quality of life, such as feeling very sedated and physically unwell (Farrelly 2002), and/or being coerced into taking it through persuasion or force (Gault, Gallaher and Chambers 2013). Hence, experiencing side effects of medication is highly prevalent and significant in decisions not to take or continue with antipsychotic medication, as well as feeling coerced into complying (DiBonaventura 2012). This experience of taking antipsychotic medication and deciding to discontinue it can result in creating distance and distrust between service users and nurses, where each has diverse opinions on the benefits and disadvantages of medication. However, other service users felt that medication was an important aspect of their treatment, in particular when they had a good relationship with their psychiatrist or nurse (Day et al. 2005). Despite the above issues many service users continue to seek out nurses on in-patient units or allow a Community Mental Health Nurse (CMHN) into their homes to try and connect with them, in order to get information, to ease felt burdens or to try and share their worries. In addition, a study carried out by Koivisto et al. (2004) found that people trying to recover from psychosis in inpatient settings need nurses to protect them from vulnerability, which is feeling safe, being understood, respected and trusted. This can occur when a nurse verbally assures them of their safety, and is available regularly and when needed.

However, other studies from a service user perspective found that at times mental health nurses spent insufficient time with them. A study by Ford et al. (1999) of service users from a medium secure unit found that 73% found talking to nurses to be helpful, but only 57% of nurse time was spent with them. While some service users recognised that nurses had a heavy workload, they also highlighted a lack of enthusiasm from nursing staff about interacting with them, which made service users believe that they were un-deserving of inpatient care. In a similar study by Barker (2000), a user led study of 343 inpatients, 57% said that they did not have enough contact with nurses, with the majority (87%) saying they had less than 15 minutes of interaction per day. As a result, they had a superficial relationship

with their named nurse (Martin and Street 2003). In a review of nurse and service user activities and interaction on psychiatric inpatient wards Sharac et al. (2010) found that on average around 50% of nursing time was spent in contact with patients, but therapeutic time spent with them was only 4-20%, with most of their time being devoted to administrative and practical tasks. However, Bowers (2013) maintains that a lot of important conversations occur with service users while also doing the practical tasks, for example when dispensing medication: in other words informal conversations occur. He suggests that admission units are unpredictable and therefore do not lend themselves to planned one-to-one meetings, while also acknowledging that sometimes staff avoid conversing with service users as it can be emotionally draining. Furthermore, there are times when service users do not want to talk to nurses.

Alternatively, some service users reported that when trust was built up with a nurse through approachability, friendliness, and perceiving them to be personable, human and empathic (Svedberg, Jormfeltdt and Arvidsson 2003), as well as inspiring hope for the service user (Cutcliffe and Grant 2001), they considered the nurse as an ally in their struggles to reach their own sense of wellness. In other words, a relationship that is built on trust is where the patient's values are respected; can play a large part in creating hope and fostering recovery (Moyle 2003). While a service user led study by Gilbert, Rose and Slade (2008) found that communication was an important aspect of their experiences with mental health clinicians, which was both positive and negative; positive when they felt listened to and the clinician was interested in their story, negative when ignored, dismissed or experienced coercive practices such as use of threats. Another service user led research found that the most important aspect of their care was being able to talk to staff (Russo and Hamilton 2007). Therefore, it appears that a lot of the difficulties are created and resolved through the quality and content of how both the nurse and service user communicate together.

In summary, it appears that service users and nurses can have different experiences of communicating together which can be either positive or negative. As professionals, mental health nurses have responsibility to be able to engage in therapeutic communications with all patients, yet many patients are dissatisfied about its quality and content. This can occur despite the fact that all student nurses learn a variety of communication models to interact and communicate with service users' experiencing psychosis when attending college, both

generic and specific, and have opportunities to learn from qualified nurses when on clinical placements. Some of these communication models and approaches are outline below.

2.3.4 Communication Models and Approaches Available to Nurses

The communications models and approaches reviewed are divided into two sections; some general models of communications available to nurses and communication approaches specific to communicating with service users experiencing psychosis.

Some General Models of Communications Available to Nurses

These models do not specifically address communicating with people who have psychosis, but are available to nurses as way to communicate and interact generally with service users. The models are the Person Centred Humanistic approach, and Empowering Interpersonal Nurse-Service User Relationships – Symbolic Interactionism Perspective

- *Person Centred Humanistic Approach*

Carl Rogers' humanistic person centred psychology (1951, 1961, and 1980) was introduced into mental health nursing communication practices in England and Wales in the early 1980's (Hopton 1997; Reynolds 1990). This approach includes communication skills, such as summarising, paraphrasing and reflecting, and incorporates the values and concepts of this approach into mental health nursing practice and according to Bowers et al. (2009, p.11), Videbeck (2009) and Hosking 1993) its impact has been "enormous". The main underpinning values are a belief that human beings are essentially social, creative beings, have an inherent tendency to become fully functioning individuals, and psychological disorders are seen as blocks to a person's attempts to reach their full potential (Morrissey 2008). The basic tenet of person centred approach is the use of the core conditions within the therapeutic relationship (Hopkins 2003), including empathic understanding, genuineness/congruence and unconditional positive regard. Empathic understanding is trying to understand what the service user is feeling from their frame of reference; it is feeling with the person, but not joining them. It encompasses understanding the person's cognition, behaviour, beliefs and emotions. It does not mean sharing those feelings but "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality..." (Rogers 1957, p.99). In order to be effective, empathy must be conveyed to the service user, who needs to be aware that the nurse is experiencing this accurate understanding. Genuineness/congruence is the ability to be genuine with service users. From a person centred approach this develops from being aware of one's own emotions and reactions in the

moment, which allows one to concentrate on the feelings of the service user. This self knowledge enables a nurse to be open and receptive, without any artificial concern about the image that is being conveyed, and with no need for defensive attitudes (O'Farrell 1999). Unconditional positive regard incorporates placing importance on the service user's worth and value as a person, a concern for his/her welfare and a respect for their humanity. It involves an acceptance of them as a person no matter what is being discussed and non-possessive warmth which conveys the genuine effort to understand (Rogers 1961). This stance need not be voiced but it is essential that it be conveyed to the service user.

The person centred approach also maintains that when individuals become aware of their difficulties, they have the capacity and tendency to move towards psychological equilibrium (Rogers 1961). Furthermore, human behaviour is purposeful and individuals are free to make and develop their own personality:

'The human being is basically a trustworthy organism capable of self-understanding and ...of making choices and of acting on these choices'.

(Nelson-Jones, 1984, p.14)

Hence, when using this perspective the nurse is encouraged to help the service user to identify and define his/her needs, then support and encourage him/her to attain them. Overall, goals are achieved through problem-solving and adhering to the core conditions.

Currently the majority of nursing textbooks include either sections on person centred therapy or outline its components as part of communication skills and ethos, and advocate its integration into nursing practice (Videbeck 2009; Barker 2009; Frisch and Frisch 2006).

However, it is proposed that the evidence for the positive impact of this approach on psychosis is poor (Bowers 2009). Furthermore, Clarke (1999) is sceptical of what he considers psychiatric nursing "wholesale acceptance of Rogerian principles" (p.2) as part of an attempt to legitimatise the profession as non-medical, without analysing its implications. He maintains that the core conditions if adhered to are impractical and contradicting. For example, genuineness/congruence implies that both the therapist and service user engage in this process, hence a nurse has to be honest with a service user, which would include both positive and negative views. In addition, this approach does not take into account the dual role that nurses engage in – the caring and custodial role. Indeed, according to Horsfall (1997) it is not seen as a central aspect in helping service users resolve or manage their

difficulties. Therefore, while Rogers's person centred approach is a component of therapeutic communications in most nursing text books, in practice it appears not to be prominent in the practice context in relation to service users who are experiencing a psychosis.

- *Empowering Interpersonal Nurse-Service User Relationships – Symbolic Interactionism Perspective*

The issue of communication within nurse-service user relationships is also addressed by Stevenson, Grieves and Stein-Parbury (2004) who endorse the assertion that all nursing care occurs in the context of interpersonal relationships. They advocate that nurse-service user communications and relationships can be understood from a Symbolic Interactionism theoretical perspective, which can aid nurses to make sense of their interactions with service users. It is maintained that this approach has the potential to enhance relationships and a service user's sense of well being.

Symbolic Interaction was initially developed by George Herbert Mead in the early part of the twentieth century. It emphasises context and the humanising effect of communication. It also pays attention to the symbolic meaning that people develop and rely upon in the process of social interaction. According to Blumer (1996) this approach is divided into three main parts, meaning, language and thought. Stevenson, Grieves and Stein-Parbury's (2004) perspective on Symbolic Interactionism focuses on meaning and the construction of reality, language as the source of meaning and thought, and as a way to facilitate understanding the perspective of service users. In essence, it states that we continually impose meaning on our social worlds, in particular, on objects, events and behaviours, and then act out of these meanings and beliefs when engaging with others. Hence, meanings and beliefs can change as new meanings are likely to be created when nurses and service users interact, which has the potential to be beneficial. Stevenson, Grieves and Stein-Parbury's perspective focuses on the skills of listening; understanding; exploring, comforting and supporting.

Listening

They consider that effective listening as a powerful aspect of communication, which requires sustained concentration, acute observation and receptivity to what is being said. The advantages of effective listening are that: it encourages service users to share their experiences; helps to create understanding between the nurse and service user; provides useful information to the nurse on what he/she needs to act on; and validates the service user as a person that has something to say. In addition, Egan (1998) outlines the following

listening skills: face the person; have an open posture; lean slightly forwards; appropriate eye contact – avoid staring; and have a relaxed posture. Environmental context is also important when listening as some service users want a quiet area, while others find it easier to talk and listen when engaged in an activity.

Understanding

Gaining an understanding of service users' experiences and views is considered important in interacting and developing therapeutic relationships. Hence, talking together and checking out understandings, in the context of showing a desire to understand the person in need is advocated. It speaks to the service user of a nurse's authenticity in his/her attempts to know their perspective. These activities build understanding and meaning. The relevant communication skills that are likely to help this process are: paraphrasing; reflecting feelings; connecting thoughts and feelings; and summarising (Stevenson 2008). This in turn encourages further interactions and deepening of the nurse-service user relationship, in particular, the positive impact of the meaning of being given time and space by the nurse.

Exploring

This is the next step in the ongoing nurse-service user relationship, which moves beyond and in tandem with listening and understanding. It allows for sensitive exploration of both pertinent but difficult issues raised by those involved in the interaction, and for more open ended discussions. In addition, it helps to identify ways of dealing with distress. To facilitate this process the following communication skills are recommended: prompting, such as encouragement and open ended statements; probing, such as open ending and closed questions, multiple choice questions; nonverbal prompts; and self-disclosure – used to encourage the service user to disclose more about him/her. Hence, exploration in a health system context requires more than just collecting facts; it means that nurses need to develop communication and interpersonal skills as care and change occurs within these interpersonal relationships.

Comforting, Supporting and Enabling

Through engaging in the above process, the psychosocial aspects of nursing are made possible and meaningful for the service user and nurse. However, it is important to note that the particular psychosocial supports identified in this step which comprise of comforting, supporting and enabling, often occur simultaneously with the previous steps. Comforting is frequently used when trying to help ease someone's distress or worry, which mental health

nurses often name as reassurance. In order for reassurance to be effective it needs to restore some confidence, and promote a sense of safety and hope, in addition to establishing some certainty for the service user about his/her difficulties or situation. The approach does not advocate the giving of bland generalised reassurance, but through listening and understanding, focus is on relevant issues. In the main, reassurance usually occurs in response to service users voicing fears and worries, being quiet and withdrawn, or making numerous requests. Supporting refers to those communications that convey being with and present for the service user when times are difficult. Its foundations are not only listening, understanding and exploring, it also includes sharing relevant information, helping people coming to terms with health problems, and examining pathways to recovery. Enabling involves partnership - a sharing of power differentials between the nurse and service user, which on a practical level enables service users being actively involved in their own care plan and in managing and/or overcoming their difficulties.

Therefore, this approach maintains that it is not enough to learn communications skills; it needs to occur in the context of human to human interaction that take place between nurses and service users. Within this context participants create meaning and act out of these meanings and beliefs. If a nurse is authentic, interested and respectful when using the above communication skills it is possible that the interaction(s) will be of benefit to the service user. It is also worth noting that learning and practising these complex skills very often is part and parcel of a nurse's working day, but habitually are not articulated or acknowledged by colleagues as an important skill. However, it only articulates what one actor in a dual communicative process between the nurse and service user, and while it seems excellent guidelines, the service user voice is absent.

In summary, these generic communication models available to nurses are mainly enacted within the context of nurse-service user interpersonal relations. It is seen as a human to human activity that both participants take meaning from, where the nurse is expected to build a therapeutic relationship with the service user. Nurses communicates with the service user for a number of reasons, such as, giving information, offering reassurance about certain worries and experiences, getting to know the service user, trying to ensure adherence to treatment plans, and jointly develop coping skills. Though, they also emphasise the importance of respect, attending to the service user's story, and using a variety of communication skills depending on what is happening within the interaction. However, the

service user's perspective is absent considering they are partners in this process, who bring their own hopes, worries and views.

2.3.5 Models and Approaches Regarding Talking with Service User's Experiencing Psychosis

The main approaches reviewed are Peplau's Interpersonal Relations theory, Bowers et al. (2009) *Talking with Acutely Psychotic People*, and Forchuk and Jensen's (2009) approaches to nursing service users with disturbing voices and beliefs.

Peplau's Interpersonal Relations Theory

'The critical elements in nursing situations are obviously the nurse, the patient, and what goes on between them'.

(Pepleu 1954 p.5)

Peplau (1952) outlined a conceptual framework regarding the therapeutic process between the nurse and patient, which is considered a cornerstone of subsequent nursing theories and the basis of all nurse-client communications (McCabe and Timmons 2011; Barker 2009b; Welch 2005; Barker, Reynolds and Stevenson 1997). Her work since then until her death in 1997 continued to have a significant influence on nurses' perspectives on patient-nurse interactions. This conceptual framework for nursing was based on Peplau's own nursing experience and the psycho-dynamic writings and work of Harry Stack Sullivan (Forchuk 1991).

One of Peplau's main focuses was on the human-to-human contact and the communication and relatedness difficulties that patients experience, regardless of clinical setting (Gastmans 1999). This approach markedly differed from the prevailing ethos of nursing custodial practices within psychiatric systems at that time. Within Peplau's Interpersonal Relations Theory framework the nurse is encouraged to offer patients an interactional experience of being understood and respected. The opinions and feelings of patients are sought, with the intent of helping them become more aware of, and make some sense of their reactions to the current situation. In addition, nurses are encouraged to strive to understand the nurse-patient interaction from the patient's perspective in order for nursing to be effective, by developing appropriate interventions (Peplau 1952). Hence, communications occur within these relationships and are influenced by such factors as environment, culture and childhood experiences. In relation to communicating with service users experiencing psychosis/schizophrenia, she outlines the following framework.

Communication with Persons Experiencing Hallucinations

Within this framework hallucinations are seen as interpersonal interactions between a real person and one or more illusory figures. This construct is based on the assumption that illusory figures are created in order to avoid unbearable emotions, such as excessive anxiety or loneliness. In these circumstances, nurses are advised to pay attention to what is happening in their interactions with the person. As Peplau (1987) maintains, it affords choices of how to help rather than just relying on traditional responses of containment. This translates into nurses being aware of their own language, such as being careful in how they phrase questions. For example, if a service user is experiencing hallucinatory voices, nurses are advised not to make these voices more real for them by asking 'tell me about the voices', instead, form a question like 'tell me about the voices you say you hear'. The intent is to cast some doubt on the service user's version, thereby, giving him/her opportunity to begin to reflect on their current beliefs. It is asserted that this process assists service users to begin to question the reality of their hallucinations, which leads to a growing awareness of the underlying issues of anxiety and loneliness. Peplau also encourages nurses to prompt those experiencing hallucinations to talk to others and avoid isolation, thereby, becoming involved in real conversations. In summary, in the context of nurse-service user interactions, nurses are encouraged to believe that they can be of benefit by being conscious of how they phrase their language, as they can help loosen service users' beliefs in their hallucinations by implying it is their internal experience that is not shared by nurses.

Communication with Persons Experiencing Thought Disorder

Peplau (1966) maintains that experiencing thought disorder is a reflection of one's inner conversations, and the longer they continue to speak openly about their psychotic worries and concerns, the more severe it becomes. Consequently, these language patterns are self reinforced. This was extrapolated from Whorf's (1956) writings on linguistics, in particular, on the assumption that language influences thought, hence, our perception and understandings. Thus, from this perspective, the focus of nurses' interaction is to respectfully correct those communication patterns deemed to fall within the remit of thought disordered speech. This is achieved by using various strategies, such as: asking direct and some open questions to invite conversations about anxieties or introducing topics for discussion if the service user has difficulties remembering events or issues; and responding to automatic knowing (by just saying, 'you know') from the service user by naming issues and inviting elaboration. The idea is that it will help the person with thought disorder to confirm or discount particular

worries or beliefs. A similar approach is used with those with a paranoid perspective, with joint gathering of evidence both for and against particular views.

The main tenet is that severe anxiety has produced thought and language disorder as a defence against it. The sources of anxiety are linked to events or issues which have been suppressed. Therefore, Peplau encourages nurses to talk to service users experiencing psychosis with a purpose; to arrest thought disorder language patterns, and to encourage and expand a service user ability to articulate their experiences. In summary, nurses' language influences service users' language, which in turn influences their thoughts, thereby, reducing felt anxiety and increasing the likelihood of being able to recognise and address underlying issues.

However, it is interesting to note that despite Peplau being considered one of the most widely acclaimed nursing theorists, McKenna (1993) found the implementation of her psychodynamic framework had become somewhat diminished within nursing textbooks. He postulates that this is a result of time and the reduced influence of the psycho dynamic approach in nursing. Furthermore, her approach has also been replaced by those interpersonal therapies that are formally scripted, standardized, focused and time-limited models that require training and advanced education and lie within the domain of carefully trained specialists (Markowitz and Weissman 2012). In summary, Peplau's approach continues to provide some useful guidance to nurses in their communications with service users, but it appears that her approach to helping those that are experiencing acute psychosis are not as readily available to nurses who currently work in Irish mental health services.

Bowers' Approach to Communicating with Acutely Psychotic Service Users

This approach identifies skills and processes that nurses employ when interacting with people experiencing acute psychosis (Bowers et al. 2009), which advocates that nurses adopt a certain moral stance when engaged in these interactions. The first stance is: *notice, do not ignore*, which refers to not ignoring what the service user says as it needs to be attended and responded to. The second stance is to: *be supportive, encouraging and gentle*. This means communicating at a pace that is comfortable for the service user, recognising the importance of engagement by listening to their story and making respectful suggestions about issues. It avoids being domineering and taking control. The third is *empathy and concern*, this stance refers to a caring and compassionate attitude that is responsive to service users' distress or aggression, and has the potential to resolve these issues and build trust. *Honesty* is the fourth

moral stance. It involves being honest about treatment plans, their views on particular beliefs and worries, and being prepared to work through any differences. The fifth moral stance is *don't intrude*, and refers to judging when to ask questions and attempting to hold conversations about symptoms, such as delusions and hallucinations, as they can be very personal to the service user. As a consequence, he/she might find it difficult to talk about them and either minimise or deny their existence, or become hostile where paranoia might be present. *Respect* is the last moral stance. This incorporates not making fun or being disrespectful of a service user's experiences, but making genuine efforts to understand the person's perspective and treating them as human beings.

These moral stances encourage nurses to prepare for interacting with service users and to be cognisant of contextual issues, and to read case notes which have information about the person's background, interests, mental health difficulties and possible risk. Nurses are also encouraged to consult with family and friends as information provided can be useful to engage with the service user. Furthermore, a low stimulus environment can promote calmness and encourages engagement, although they caution nurses to be mindful of risk regarding hostility and aggression when meeting service users on a one-to-one basis.

When looking specifically at talking to service users who are reporting hallucinatory experiences, allowances need to be made and tolerance needs to be shown for these internal experiences when in conversation. It is maintained that this is necessary, as they could be distracted when trying to attend to various internal and external voices, while conversing with a nurse. Therefore, they advise to be patient and take a pragmatic attitude, use the service user's name more often as it appears to ground them in the here and now, and also be careful with the amount of information given, and the context it is given in. For example, noisy areas, coupled with excessive information can cause agitation and/or disengagement. Establishing what nurses may inquire about and represent to the service user is also important. Therefore, nurses seek permission to attempt to encourage reflections by the service user on his/her belief(s) that the voices external exist. If given, engaging in the joint exploration of identifying links between felt stress and an increase in voice hearing experience is encouraged, as well as problem solving causes of stress. One other reason why nurses are keen to discuss the content of voices is risk assessment, as some can experience command voices to hurt themselves or others.

With regards to those with thought disorder, emphasis is placed on acceptance and listening with non-verbal cues and encouraging phrases. This approach, over time, will give the nurse a good understanding of the person's world, which in turn enables the nurse to provide more effective assistance, by giving targeted help. For example, where appropriate and within the context of a nurse-service user relationship, linking delusions to past or current events can assist in diminishing what are considered delusional beliefs. Other recommendations are: summarising and naming themes that have arisen; reminding and prompting if they appear to have lost their train of thought; if possible keeping to one topic at one time, and clarifying issues when needed. As above, gaining knowledge of the content of delusions from a nursing perspective aids risk assessment, as it is considered that there can be a link between delusions, behaviour, and risk to self and others. In these circumstances, the direct challenge of the delusion can occur. Another recommendation is not to collude with the delusion by agreeing with the content as real. However, this process also enhances the social connection between the nurse and service user, as well as the service user's concerns about being treated in a serious way.

In summary, Bowers et al. (2009) assert that this approach provides a framework for how nurses can talk to service users experiencing acute psychosis in a way that is beneficial. In particular, they emphasise the importance of nurses engaging with service users in a human to human way that treats their concerns in a serious manner, and highlights that these interactions are complex. Hence, the nurse has to constantly monitor and be flexible regarding which approach will be most helpful at any given time. In summary, while this approach appears to contain useful recommendations for nurses in their communications with service users it does not include the voice of the service user. Consequently, this begs the questions, how do service users manage their communications with nurses, and how do they influence communications between them as one of the actors in this dialogue?

Forchuk and Jensen's Approach to Nursing Service Users with Disturbing Voices and Beliefs

This approach by Jensen and Forchuk (2009) outlines ways of communicating with service users experiencing acute psychosis in the context of a good nurse-service user relationship.

'The primary nursing role related to hallucinations relate to interpersonal approaches. The primary intervention is always to establish a therapeutic trusting relationship'.

Forchuk and Jensen, (2003, p.248).

Forchuk and Jensen outline different roles that a nurse has in relation to interacting with service users experiencing psychosis. One of these is the biomedical approach where nurses are expected to administer, monitor and document therapeutic and side-effects of anti-psychotic medication. This also includes promoting compliance of medication and treatment plans.

Another role for nurses is helping service users develop individualised ways to cope with hallucination by jointly identifying patterns when hallucinations are more severe and quieter, through self-monitoring of the experiences. The main recommended ways of coping are listening to music, talking to others, saying 'stop', naming objects, humming, exercise and self talk. The intent is to distract or drown out the hallucinations, to give the service user tools to manage these experiences especially if they are distressing. They also recommend Peplau's (1963) suggestions to provide them with opportunities to interact with others to decrease their sense of loneliness, and help the service user identify the anxiety behind the hallucination. In addition, they promote Clack's (1962) strategy to help the service user to observe and describe the hallucinations, which help build trust and understanding, identify any underlying issues and address their needs.

Jensen and Forchuks' (2009) understanding of delusions maintains that it is one of several possible defences against long standing anxiety and insecurities, and that these beliefs have a truth at their core, which implies that past issues and trauma are important. However, they also describe delusions as appearing "bizarre and irrational" (p. 210). Hence, nursing care needs to be provided for the particular delusion being suffered, and by letting the service user express their feelings about their beliefs they can identify anxieties that need to be addressed. The greater the understanding of the service user's beliefs (information can be also obtained from family and colleagues), the greater chance the nurse has to weaken the delusion in conversation with the service user. This happens through the joint gathering of evidence against the belief where eventually the service user can doubt his or her perception regarding the reality of the delusion.

Other issues they deem that the nurse needs to consider are their own frustrations, for example if the service user does not take his or her view on board, in relation to the safety of the themselves and service user it is important to not agree or argue with service user about the content of their delusion. They also note that when talking to people in psychosis, nurses feel that they are walking a tightrope, as they neither want to re-enforce the delusion nor

come across as dismissing the person. Thus, this approach advises nurses to validate the person who has worries, but also to indicate they do not have these beliefs, for example, “I don’t feel or see the snake, but I believe that it is real for you” (p.210).

Overall, Forchuk and Jensen acknowledge the dual role of the nurse in relation to service users where they are tasked with encouraging and sometimes ensuring compliance with treatment plans. They also give advice on how to help service users manage and diminish auditory hallucinations and delusions and acknowledge some of the difficulties and anxieties that nurses experience within nurse-service user communications. Yet, they overlook such issues as the importance of conversing with service users in a serious manner, difficulties in developing therapeutic relationships, and expanding on ways to explore past issues/traumas, apart from listening to the service user’s story.

This section of the literature review contextualised issues relating to some general and specific communication models available to nurses when conversing with service users. Communication between the two groups is seen as a human to human activity that both take meaning from. Within these encounters nurses are expected to initiate and build a therapeutic relationship with the service user in order to: give information; offer reassurance about certain worries and experiences; get to know the service user; ensure adherence to treatment plans; and jointly develop coping skills. All communication approaches reviewed emphasise the importance of respect, attending to the service user’s story, and using a variety of communication skills depending on what is happening within their communications. Some outline how to communicate with those experiencing psychosis and give advice on how to listen and respond appropriately to the service user’s worries; in particular, how to intervene and help service users manage some of the symptoms of psychosis, such as hallucinations and delusions. However, these models are presented from only one perspective that implies that if nurses follows certain guidelines and advice, and structure their communications in a certain way, it is likely that it will benefit the service user in managing or overcoming their difficulties. Yet, as the other communicative partner, service users also significantly influence the development, maintenance and ending of their joint communications.

2.4 Summary

A number of perspectives on psychosis and communication between nurses and service users experiencing acute psychosis have been postulated, which the author has situated within the broad categories of a number of models. Each model provides a perspective on psychosis

and/or communications, its impact on service users and nurses, and guidance for social, moral and professional practice.

Relevant to this study are the dominant discourses within the realm of mental health, which in Ireland is the biological/biomedical and to a lesser extent biopsychosocial model, with cognitive and dialogical perspectives slowly gaining some prominence. In addition, the service users' subjective experiences and those critical of psychiatry were attended to. The articulation of these discourses has assisted in understanding the offered approaches and treatment by mental health care services in Ireland to those who experience psychosis. Those discourses that have been critiqued indicate that for service users with acute psychosis the biological/biomedical model remains dominant until such a time that doctors and nurses deem that the person is 'well enough' to engage in other forms of treatment, thereby excluding alternative perspectives. Furthermore, this approach can have a stigmatising and disempowering impact on the service user. Nurses who are involved in care of service users are influenced by the dominant biological/biomedical approach resulting in a focus on medication compliance, risk management, and communicating with the intent to ascertain what is considered the service user's levels of unwellness/wellness. Hence, in the main nurses temporally put aside learned communications approaches. However, there are also occasions that nurses try to connect to service users on a human level, seek and encourage the service user to tell his or her personal narrative with the intent of understanding the other's perspective, and actively engaging in ways to help the service user on his/her recovery journey.

With regards to service users' experience of communicating with nurses, some expressed dissatisfaction with its quality and content as well as biological/biomedical treatments offered; treatments that nurses promote and occasionally enforce, nurses apparent lack of interest and experiencing disempowerment. Yet, service users also report positive communicative experiences that contribute to their sense of wellness. Therefore, it is considered appropriate to explore how nurses and service users experiencing acute psychosis manage to communicate together in the context of employees and attendees of an Irish Mental Health Service using a Classic Grounded Theory methodology. The following chapter will describe the Classic Grounded Theory methodology employed in this exploratory study.

Chapter 3. Methodology: Classic Grounded Theory

3.1 Introduction

This chapter will describe the methodology used in this study; Classic Grounded Theory (CGT), as articulated mainly by Barney Glaser (Glaser and Strauss, 1967; Glaser 1978, 1998, 2002, 2004). The chapter also provides the rationale for the choice of methodology and situates it within the wider domain of knowledge generation. Methodology can be defined as “the system of methods and principles used in a particular discipline” (Collins 2003 p.1026).

3.2 Underpinning Ideas

When engaging in social research, most methodological approaches are underpinned by a perspective on the nature of knowledge and of knowing (Crotty 1998). Hence, Crotty encourages researchers to reflect on and articulate, not only to the reader, but to him/herself, the theoretical, epistemological and ontological and methodological underpinnings of their research. Therefore, situating CGT philosophically is important as there are different versions of Grounded Theory methodology that position themselves (or are placed) in particular ontological (the nature of reality) and epistemological (the relationship between the inquirer and the known) spheres. Where appropriate, these debates on competing views of Grounded Theory will be woven into this particular articulation of CGT as this researcher understands it. Furthermore, in the carrying out of research, there is an understanding that a researcher is influenced by his/her ontological and epistemological positions, and despite what paradigm one adheres to, one’s position becomes partially self-validating (Guba 1990). Therefore, the researcher has to be aware of his or her interpretative framework throughout the research process, as this impact on the way one conducts research and the outcomes of the research.

3.3 Role of Literature in a Grounded Theory Study

The role of existing theory and literature in CGT research differs from conventional methodological approaches to literature reviews, as Glaser (1998) advises not to complete a literature review in the specific area of interest prior to engaging in the proposed substantive area of study. His concern is that the researcher could become influenced by existing knowledge and assumptions gained from an in-depth review, which could be used as a source of concepts that neither ‘fit’ nor are relevant to the emerging theory. Hence, it risks preconceived ideas being forced into the study. Instead, he advises the researcher to be “as free and as open as possible to the discovery and to emergence of concepts, problems, and

interpretations” (Glaser 1998, p.67). This could include ideas from the literature review once they are subjected to full conceptual integration, and only if they have fit and relevance; it integrates into the emergent theory. However, this has led to some confusion regarding the place of the literature review in a grounded theory study, as some have interpreted his advice as an instruction not to read any literature (McCallin 2006). This approach has caused concern, due to the expectations of academic supervisors and institutions, that an initial comprehensive review of literature be completed to aid in the identification of a research problem, discover gaps in the literature, demonstrate researcher knowledge of the topic under study, to outline appropriate research methods (Hart 1998), and provide a rationale for this study.

However, according to Andrews (2006) the confusion about Glaser’s advice arises partially from the development of “the continual re-writing of the Classic Grounded Theory method” (p.29); where different versions of the Glaser and Strauss (1968) Grounded Theory method have been developed. The main ones are Strauss and Corbin (1990) and Charmaz (2006). Another issue that contributes to the confusion about a literature review when doing a CGT study is a misreading of what Glaser recommends. He advocates a preliminary reading of theory not directly associated with the specific research field to help the researcher to develop theoretical sensitivity, an in-depth reading of the method, and attending research methods classes (Glaser 1998). So, the question is what to read rather than whether to or not.

The CGT literature review begins when the main concern and core category are identified, and its content is constantly reviewed as concepts and categories emerge. It is also used to support and illustrate the theory (Nathaniel 2006). In the context of this thesis, part of the requirement of academic registration was a written demonstration of knowledge of the literature and theory pertaining to the phenomenon to be studied in order for the academic supervisor to evaluate the proposal. Therefore, a preliminary review was conducted. This researcher considered that this preliminary literature review helped to develop theoretical sensitivity, to be open to what was happening in the data, and to become sensitised to emerging concepts (Glaser 1978). Theoretical sensitivity is when an ability to sense the intricacies of the data. Therefore, a literature review was also conducted concurrently with data analysis and theory development which was guided by the emerging concepts. Hence, the literature presented in this chapter comprises of both the pre-review and the review as the

study progressed. Further justification for this study is woven into this review and into the subsequent chapter.

3.4 Overview of Grounded Theory

Grounded Theory is a methodology developed by two sociologists, Barney Glaser and Anselm Strauss, for the purpose of building theory from data primarily within the field of social research. Their book, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (1967) outlines a systematic method for data collection and analysis, in order to construct a parsimonious theory that is grounded in the data, so as to explain patterns of behaviour regarding what people do (Glaser 1998).

Grounded Theory maintains that the theory is only relevant if it has fit, relevance and workability related to a specific study; as a consequence, the researcher seeks to discover what is ‘going on’ for people in the substantive area of study. In other words, the theory has to make sense to a reader, clear that the developed theory comes from the data, needs to fit the social scene studied, and must have sufficient abstraction as it might apply to other social or psychological situations (Stern 2007). One of the assumptions of Grounded Theory is that human behaviour involves what Glaser names “a latent pattern” of behaviour, which of people are generally unaware (Glaser 1998, p.117). Therefore, the goal of Grounded Theory is to generate a theory that accounts for these patterns of behaviour; making the latent patterns visible which help people resolve or manage relevant issues/situations. To achieve this, the researcher attempts to understand participants’ perspectives regarding problems, actions and meaning (their main concern) and create an explanatory theory on how they continually process and resolve their main concern.

CGT was developed by Glaser and Strauss to remind researchers who used qualitative methods that the generation of theory was just as important (and possible) as its verification. This was deemed necessary as it was considered that quantitative research methods dominated the social research field; methods which mainly focused on statistical-quantitative mass surveys (Bryant and Charmaz 2007). In fact, Kathy Charmaz (a past student of both Glaser and Strauss) maintains that the development of Grounded Theory provided a “cutting edge statement” as it challenges the notion that qualitative research is not ‘proper’ scientific research method, and that only quantitative ways of knowing were valid (2006, p.5). Glaser and Strauss attempted to introduce a balance by developing systematic strategies for qualitative research practice, which took the middle ground between the philosophical and

methodological divides of quantitative and qualitative approaches in social science. They developed a general method (Glaser 1998), that can be used to analyse both qualitative and quantitative data. This researcher used only qualitative data in this study.

3.4.1 *Debates within Grounded Theory*

There has been debate in the Grounded Theory field over the last twenty five years or so regarding the nature, purpose and processes of Grounded Theory. Glaser (1998, 2003, 2008) maintains that ‘remodelled’ versions of the method that have developed over the intervening years since his collaboration with Anselm Strauss have deviated from the original Grounded Theory method, and as a result cannot now be called Grounded Theory. These versions include: Constructivist Grounded Theory (Charmaz 2000, 2006), Dimensional Analysis (Bowers and Schatzman 2009; Schatzman 1991), and Situational Analysis (Clarke and Friesen 2007; Clarke 2003). In particular, two distinct versions of Grounded Theory have emerged between Glaser and Strauss, a divergence influenced by their academic backgrounds and different career paths after their collaboration (Morse 2009). Glaser’s version has become known as Glaserian or Classic Grounded Theory, (Glaser 1978, 1992, 1994, 1996, 1998, 2001, 2003, 2006), while Strauss’s version is known as Straussian Grounded Theory, (Corbin and Strauss 2008; Strauss and Corbin 1998, 1990; Strauss 1987). One aspect of the debate has centred on the philosophical influence and the input each founder had on the development of Grounded Theory. Some writers highlight the influence of symbolic interactionism on Strauss’s perspective (Alvesson and Sköldberg 2009; Clarke 2009; Annelis 1996), while others have emphasised Glaser’s contribution based on and his adherence to what they consider as the original Grounded Theory method (Hernandez 2009; Holton 2009; Christiansen 2008). The process of doing CGT includes: data collection – initial analysis determines where to go next; finding participants main concern and core category; constant comparative analysis; memoing, sorting and theoretical outline (Simmons 2014).

Glaser (2004) states those remodelled Grounded Theory approaches that do not adhere to the original method are not Grounded Theory as fundamental aspects of the original method have been changed, so much so, he claims that instead they are conducting “qualitative data analysis” (QDA), rather than doing Grounded Theory (Glaser 2002, p.2). QDA refers to the way qualitative data is analysed and where researchers stresses the socially constructed nature of reality and uses an interpretive lens to examine the meaningful and symbolic content of qualitative data with the aim to identify themes (Taylor and Gibbs 2010). According to

Glaser (1998) QDA's goal is description of the phenomenon under study (CGT goal is conceptualisation) and is preoccupied by "worrisome accuracy" (p.2) about the accuracy, truth and trustworthiness of the data. However, this does not mean that CGT is not concerned with these concepts, but they do not provide appropriate criteria for assessing the quality of a grounded theory as it a general method (Holton 2008). Glaser and Strauss (1967) and Glaser (1978) established criteria by which the quality of a grounded theory should be assessed. The four criteria are fit, work, relevance and modifiability.

'Fit refers to the emergence of conceptual codes and categories from the data rather than the use of preconceived codes or categories from extant theory. Work refers to the ability of the grounded theory to explain and interpret behaviour in a substantive area and to predict future behaviour. Relevance refers to the theory's focus on a core concern or process that emerges in a substantive area. Its conceptual grounding in the data indicates the significance and relevance of this core concern or process thereby ensuring its relevance. Modifiability refers to the theory's ability to be continually modified as new data emerge to produce new categories, properties or dimensions of the theory. This living quality of grounded theory ensures its continuing relevance and value to the social world from which it has emerged.'

Glaser and Strauss (1967pp. 237-250) and Glaser (1978pp. 4-6)

According to Simmons (2011) most of the variations of Grounded Theory that Glaser referred to as remodelled can be included under Charmaz's (2006) constructivist version of Grounded Theory.

Charmaz (2006, 2005, 2000) contests Glaser's assertion that her approach does not fit the criteria of Grounded Theory, and counter claims that CGT continues to adhere to objectivist/post-positivist leanings as it erases social contexts, assumes there is an external reality to be discovered, and assumes that researchers are unbiased observers who record facts. In particular, is critical of the idea that CGT researchers should have no preconceived ideas about the substantive area before entering the particular research area. While Dey (1999) claims that this approach is similar to naïve inductivism, where one enters the research field with a blank mind or tabula rasa, which he believes is unrealistic. An objectivist/positive ordination is usually associated with empirical science, deductive and quantitative methodologies. However, Grounded Theory is primarily an inductive methodology, as it starts with the data and builds a theory based on systemic analysis of the data, rather than using existing theoretical perspectives. There is some deduction in Grounded Theory. For example, theoretical sampling is a deductive process that directs the researcher on where to go next for comparative data.

‘... it is carefully deducted probabilities on where to go next for what data one might find to induce further a growing theory’

(Glaser 1998 p.43).

Charmaz (2006) also asserts that CGT does not address issues such as the role and influence of the researcher in gathering the data and its analysis. These issues are considered important to address from a constructivist position, as theory development is not only seen as an interpretation, but also viewed as a co-construction between the researcher and the participants. A constructivist ordination maintains that individuals construct their own interpretation of the world through their belief systems, senses, nervous system, and events that they observe (Carr 2000). This approach uses inductive and qualitative methodologies, which try to understand and explain phenomena. Charmaz asserts that her approach is based in the interpretive tradition which emphasises understanding and interpreting the phenomena under study, rather than just explaining it. Therefore, it does not seek participants’ main concern or a core category that articulates how participants process or resolve it. However, while Charmaz names her approach as constructivist, it also appears to draw from a social constructionist perspective when she talks about co-construction and people constructing their social world. Hence, she situates her Constructivist Grounded Theory within the broad interpretive tradition (Charmaz 2006). It is also important to note that this researcher includes some of Cathy Charmaz’s understanding of Grounded Theory when describing the CGT viewpoint even though she speaks from a constructivist perspective. This is possible as she is a past student of Glaser (and Strauss), and up to a point she adheres to CGT methods. For example: open coding; coding incident to incident; using comparative method; raising codes to higher conceptual levels; seeking theoretical integration; memo-writing; theoretical sampling; and saturation. Therefore, it is justified that relevant segments of her writings be included.

According to Holton (2008), remodelled versions of Grounded Theory require researchers to reflect on and articulate its own bias, prejudices - such as power, gender, and social class - and impressions as the study progresses. She deemed attending to these issues important as the research process is considered a co-construction between the researcher and the person. Conversely, Glaser (2003) maintains that while these are important issues, they should only be included if they earn their way into the analysis, otherwise it encourages preconceptions and forcing professionals’ ideas onto the research. Therefore, it could introduce issues that

have not come forth from the data, which would distort the research process itself as it can lead to theoretical stagnation and limited results (Glaser 1998).

The issue of managing researchers' biases, prejudices, or one's favourite concepts or ideas so it does not distort findings is important; it is seen as a marker of a good quality research that these issues are addressed. Those who adhere to CGT methodology say that it is a conceptual method rather than a descriptive one. Therefore, it transcends descriptive methods and their associated problems of accuracy, interpretation and constructionism, by engaging in conceptualisation, which "is not an act of interpretation; it is an act of abstraction" (Holton 2008, p.76). This frees the analyst from the above concerns, as the data is theoretically explained rather than described. Another way that the CGT process manages preconceived ideas being forced onto the data is to remain open to what is happening in the substantive area under study. Rather than entering the field with a blank mind, Glaser recommends the researcher be "as free and as open as possible to the discovery and to emergence of concepts, problems, and interpretations" (Glaser 1998, p.67). He also recognises that while it is human to carry biases, it is important to try and reduce them by holding lightly one's beliefs and favourite concepts, avoiding using preconceived questions or structured interviews, continually studying the data, conceptualising and constantly comparing. In other words, the process of doing a CGT study will make it obvious if a concept is being forced as it will not fit or be relevant. Therefore, adhering to the process of doing CGT helps to manage bias and ensures that theories systematically emerge from the data (Simmons 2011). This does not mean that they suddenly appear; they develop as a result of the researcher's diligence, a constant interplay between the theory and the data using the constant comparative process, and theoretical sampling.

3.5 Rationale for Using Classic Grounded Theory

The previous chapter demonstrated that there is an extensive, broad and evolving understanding of the concept of psychosis and its impact on the individual, his/her family and nurses, and service users' and nurses' joint communications, which has a significant impact on both groups; it matters to them. However, there are some identified knowledge gaps in relation to how nurses and people experiencing acute psychosis deal with communicating together. For example, it is not clear how service users experiencing acute psychosis and nurses decide what is okay to say and do when talking with each other in the context of a mainly biomedical approach to psychosis within an Irish Mental Health service, and how this

can inform nursing practice and service user support groups/organisations in responding to their needs (Hem 2008; Ockwell and Capital Members 2008; Koekkoek, Van Meijel and Hutschemaekers 2006). This study sought to address these gaps by exploring this subject directly with service users who had experienced psychosis (and communicated with nurses while attending a mental health service), and mental health nurses who had cared for service users experiencing acute psychosis.

The use of CGT is appropriate for discovery orientated research in areas that are under-theorised, and with issues that are somewhat concealed, and unanticipated. CGT is considered a general methodology that can use quantitative or qualitative data. In particular, it is suited to research where little is known about the phenomenon of interest. It facilitates the collection of rich data so a deeper understanding of the subjective experience regarding a particular event can be ascertained (Artinian 2009), how those who are at the centre of the issue understand the world, their rules for behaving and what holds meaning for them (Kottak 2006). Furthermore, CGT is a “theory generating methodology” (Glaser 1998, p.5) that reveals fundamental patterns in the substantive area, aims to produce theory that is understandable and useable to those most concerned with what is happening in the substantive area, and can contribute to practice. In particular, this researcher is attracted to CGT’s facilitation of finding a shared main concern and core category of both nurses and service users and how it is continually processed or resolved, as it is likely that the resultant theory will have relevance to both groups, thus, fulfilling the overall aim of the study by addressing theoretical gaps through the generation of a new theory, which seeks to identify and explain patterns underlying social phenomena (Glaser and Strauss 1967): for example, the processes that service users experiencing acute psychosis and nurses engage in to resolve or manage their concerns. This is important for nurses and service users, as their subjective views on how they decide what to say and not to say when communicating together are absent, views that can contribute to professional and service user discussion on practices that are useful and beneficial.

In summary, CGT was chosen rather than other methodologies, as it was considered that it provides the most clear and flexible steps to explore and develop theoretical conceptualisations that can guide practice. In particular, given the lack of research that theoretically explains communications between service users experiencing acute psychosis and nurses relevant to how they decide what to say and do when communicating together,

this study aims to identify their joint main concern and to generate a substantive theory explaining the processes which they engage in to resolve this concern. In addition, this theory is intended to inform mental health professional practice and knowledge with the intent of developing responses to nurses and service users regarding communicating together. Considering that many services users have had both negative and positive experiences with mental health clinicians, lack of opportunities to articulate their subjective accounts, and sensitivities associated with their diagnosis, one-to-one in-depth interviews were used. This approach was also used with nurse participants. These interviews were the main source of data, which was all qualitative.

3.6 Classic Grounded Theory: Methodological Framework

'Grounded Theory is the systemic generation of theory from data acquired by a rigorous research method.'

(Glaser 1998, p.3)

Grounded Theory was developed by Glaser and Strauss (1965) when they collaborated on researching death and dying in hospital settings. This led them to articulate the processes and procedures necessary for a methodical approach to theory development (1967).

The following procedures are central to the Classic Grounded Theory method: the coding process, the constant comparative method, the core category emergence, theoretical sampling and memoing. They are used to guide the analytical process for the development, fine-tuning and identification of the interrelationships between concepts (Charmaz 2006), and all are guided by the emerging theory (Glaser 2001).

3.6.1 The Coding Process

Coding is a core process in CGT methodology, as it through coding that the researcher can raise the raw data to a more conceptually abstract level; by breaking down the data, and putting it back together conceptually (Holton 2010; Strauss and Corbin 1990). There are two types of coding in a CGT: substantive coding, which includes open and selective coding procedures, and theoretical coding which conceptualises how the substantive codes may relate to each other. In CGT, the process of coding is not a separate stage in itself, but it is a continuous feature of the analysis. It is also important to remember that the collection and analysis of data is a simultaneous process; analysis starts after the first interview (Hallemor 2006; Glaser 1998).

Conceptualisation of data is the bedrock of CGT development where the relationship between data and theory is a conceptual code (Holton 2010). Coding is where the categories and their properties are generated, as it facilitates the researcher to fracture the raw data, then conceptualise the pattern of a number of empirical indicators from within the data as a theory which explains what is happening in the data, and gives the researcher compressed abstract view of what appears to be dissimilar phenomena (Holton 2007; Strauss and Corbin 1990).

Substantive Coding

Substantive coding is the process of conceptualising the data in which the theory is grounded (Artinian 2009; Glaser 1998), and includes an open and selective coding. The process begins with initial open coding of data, to the emergence of a tentative core category, followed by delimiting of data collection and through selective coding and analysis. .

- *Open Coding*

This starts with working directly with the data where it is broken down through coding it line by line, and comparing incidents to each other in the data. The researcher asks certain questions of the data: what is the main concern/issue being faced by the participants? What accounts for the continual resolving of this concern? What is this data a study of? What category does this incident indicate? And what is actually happening in the data? (Holton 2007; Glaser 2004, 1998, and 1978). This allows the researcher to move from the descriptive to focusing on patterns amid incidents that produce codes, which also ensures relevance of the emergent theory. Hence, it is the pivotal link between collecting data and developing an emergent theory to explain this data. These codes can be in ‘in vivo’, in that they come from the language of the participants, or in ‘in vitro’, where the code is constructed by the researcher which reflects the data. Glaser (2001) is critical of researchers who use coding concepts from other theories that have not earned their way into the theory, hence do not fit. Open coding also implies that the researcher should remain open to what emerges from the data and not impose his or her preconceived ideas.

This initial coding also includes searching for a tentative core category and related categories (concepts), through using the constant comparative method (see below). These codes show how one selects, separates and sorts data to begin an analytic interpretation. They are compared with each other with a view to identifying social and psychological patterns and assigning conceptual labels to each set of incidences. In addition, coding involves using action verbs (gerunds), which help the researcher to detect processes and to stay close to the

data. Hence, it assists him/her to get a strong sense of action and progression relating to the studied area (Charmaz 2006).

- *Selective Coding*

Once a tentative core category and its major dimensions are identified delimiting for selective coding occurs, which means limiting coding to those variables that are related to the core category (Giske and Artinian 2009). Therefore, certain categories are excluded from the study as it progresses, decides where next to collect data, and helps to saturate the remaining categories quicker as there is less material to be analysed. This ensures that the data continues to be relevant to the emergent theory.

- *Theoretical Coding*

Theoretical coding relates the concepts of a theory to each other in a clear and distinct way as it conceptualises how the substantive codes could relate to each other as multivariate hypotheses when integrating the theory, and gives integrative scope, broad pictures and a new perspective for resolving/managing the main concern (Glaser 2005: 2002; 1998). Similar to substantive codes, theoretical codes have to emerge from the data and must earn their way into the theory (Holton 2007; Glaser 1998). As a consequence, Glaser (1992) was critical of Strauss and Corbin (1990) advocating that the researcher could use preconceived general codes, such as cause, context, contingencies, context, covariances and condition (the six C's), rather than applying them only if they emerge from the data. Theoretical coding also helps the researcher to maintain their conceptual level when writing about concepts and how they relate.

Hence, the conceptualisation of data through coding gives rise to different conceptual categories and their properties (indicators of the pattern that constitutes the category). These categories and associated properties are conceptual and abstract, not descriptive.

3.6.2 Constant Comparative Method

'The constant comparative method enables the generation of theory through systematic and explicit coding and analytic procedures'.

Glaser and Holton (2004, p.10)

The constant comparative method is an ongoing process that guides the development of the emergent theory which starts after the initial collection of data occurs and stops when the

theory is being written up. Its purpose is theoretical elaboration, saturation, and verification of concepts.

Initially, when employing the constant comparative method, the analyst compares indicator (code) to other indicators that were generated from the analysis of his first data set. This occurs in order to develop a higher conceptual code or concept, which encompasses the significance of the indicators. When emerging concepts are identified other indicators are compared with it to find differences, likeness or varying conditions to generate new theoretical properties (Holton 2010). According to Glaser (1998) this has a number of functions as it verifies the concept as a category: it represents a pattern in the data, it confirms the fit of the pattern, it generates properties of the categories, and it saturates the category. Then emerging categories are compared to each other so as to find the best fit while at the same time identifying its properties. Throughout this process the researcher needs to keep asking these questions:

'What category does this incident indicate? Or what property of what category does this incident indicate? And lastly what is the participant's main concern?

(Glaser 1998, p.140)

Comparing concept to concept also helps to identify which concepts have greater explanatory power regarding similar indicators and helps with the developing theory by indicating how different concepts are linked and integrated. This process is called inter-changeability of indicators, which:

'Forces the researcher to confront similarities, differences, and degrees of consistency of meaning between indicators, generating an underlying uniformity which in turn results in a coded category and the beginnings of the properties of that category'.

Holton (2010, p.29)

The constant comparative method has also delimiting features which helps the research to focus more on the theory. These are: it helps to resolve "data overwhelm" (Glaser 2004, p. 24), as it involves alternating data collection, coding and conceptual memoing, thereby stopping the researcher from collecting superfluous data; another way is when the researcher finds similarities in concepts or properties and can merge them into fewer higher level concepts; and when each category becomes saturated, so no new conceptual properties or dimensions are emerging. In addition, delimiting also occurs when the theory reaches a point where the researcher focuses on the core category and sub-core categories.

3.6.3 Theoretical Saturation

The challenge of knowing when to stop data collection is recognising that the point of theoretical saturation has been reached (Glaser 1998). According to Charmaz (2006) this is when gathering more data yields no new theoretical insights, nor new properties of theoretical categories. This occurs through the use of the constant comparative method until no new properties or dimensions are emerging. At this point, theoretical concepts are at an abstract and general level, but continue to retain a link to the data. Therefore, through using coding and the constant comparative method the researcher is constantly looking for the core category. Through the process of coding, analysing and theoretically sampling the researcher becomes sensitised to possible core categories. The chosen category has to relate meaningfully and easily to as many other categories and their properties as possible, and account for a large part of the variation in the substantive area. The core category also helps the researcher through the analysis by providing a way of conceptualising and organising participants' issues, by its relevance and explanatory power.

3.6.4 The Core Category Emergence

The core category (sometimes referred to as the core variable) appears to explain how the main concern of the participants is constantly processed or resolved. According to Glaser (1998, p.115), "understanding and accounting for these actions from the perspective of the participants' in the substantive area under study", is what defines grounded theory. Therefore, its main function is to integrate the theory by making it dense and saturated. Although the above might appear a straightforward process, identifying participants' main concern is somewhat complex for the researcher as there were two distinct participant groups included in this study. Therefore, finding a main concern that encompassed both groups was challenging as at times what appeared to be a main concern applied only to one group. For example, at one point it emerged that the main concern was centred on the psychosocial process of *being silenced*; in relation to what could and could not be said in conversation. However, this tentative main concern did not pattern out as it mainly applied to service users. Later, a possible main concern that spanned all groups was identified as, *avoiding possible dire consequences when conversing with each other*. However, when memoing this issue the concept of permissibility came forth and the main concern was then renamed as *establishing permissible communications*.

The resultant core category has to be central, it relates to as many other categories and their properties as possible, and accounts for a large portion of the variations in a pattern of behaviour that accounts for its continual resolution (Holton 2007). Hence, the core category forms the basis for the emergent theory, which is usually constructed around the identified fundamental latent pattern; the general social psychological process (Glaser 2007). It works and is relevant, meaning it should be able to explain what is happening in the area under study, and it is relevant because the method allows core process and related processes to emerge from the data; it leads to theoretical completeness (Glaser 1998, 2005). If a core category is not employed, the theory development will drift in relevance and workability, because identifying the core category has delimiting functions.

3.6.5 Memo-Writing

Writing theoretical memos is an essential aspect of Grounded Theory methodology as it is the vital step between data collection and writing drafts of the theory, in that they are the theoretical notes about the data and conceptual connections made between categories (Holton 2007). Memoing allows one to stop and analyse ideas about the codes within the moment, which Glaser (1998, p.177) refers to as “moment capture”: it happens as the coding, collecting, theoretically sampling, and analysing the data occurs. The capturing of ‘moments’ refers to the researchers developing ideas relating to the coding processes, which are then written down. The process of writing memos occurs continually to help raise data to a conceptual level and develop properties or dimensions of different categories; it leads naturally to abstraction. As memos are written up, they are ‘banked’ for further later elaboration. The process of memo writing can occur at any time or place, and as a result the analyst is encouraged to always carry a notebook with him or her; stop and memo is Glaser’s (1978) advice. These short memos are later coded and written up.

Writing hypotheses to define relationships between categories helps to integrate the overall theory (Holton 2010). Charmaz (2006) maintains that memoing helps the researcher to clarify what is happening in the field under study; in particular, using memos to raise substantive codes to conceptual level, and moving from descriptive to conceptual writing. As indicated above, memos also helps with theoretical sampling by clarifying what directions to take and possible questions to answer and linking concepts.

3.7 Summary

In this chapter the researcher gave an overview of Classic Grounded Theory methodology, where it is situated within the broader field of Grounded Theory, and how it is situated within different domains of knowledge. Debates within the field of Grounded Theory were outlined and the researcher's positioning regarding these debates. A rationale for why CGT is appropriate for this study was articulated, in addition to some of the key principles and practices that underpin the methodology. An argument was also put forward that as CGT is considered a general method it differs from qualitative research in particular how it is judged regarding trustworthiness. The criteria developed by Glaser and Strauss (1967) are criteria are fit, work, relevance and modifiability.

Grounded theory evolved from the collaborative work of Glaser and Strauss (1967) and offers researchers a way to systematically generate theory. A CGT study identifies fundamental processes in the substantive area which is conceptualised by the core category. In this study such processes were concerned with service users of mental health services that had experienced acute psychosis, and mental health nurses' main concern in relation to communicating together and how they resolved this, which enhances the field of nurse-service user communications. Considering the lack of practical guidance for clinicians working with service users experiencing acute psychosis this methodology was deemed appropriate to progress this goal. In this study a literature pre-view was conducted not only as a requirement of academic registration, but also to increase the researcher's theoretical sensitivity to related concepts. The literature review commenced when the main concern and core category were identified.

Within this chapter this researcher highlighted how CGT has its own inbuilt system to help the researcher remain open and reflexive in relation to his or her possible impact on the study. Drawing on the ideas presented in this chapter, the next chapter discusses how the methodology was operationalised in the conduct of this study.

Chapter 4: Methods: Applying Classic Grounded Theory Methodology

4.1 Introduction

This chapter outlines how the CGT methodology delineated in the last chapter was enacted. It describes the study's aims and objectives, design, and procedures. Finally, ethical considerations related to the study are discussed.

4.2 Aim and Objectives

The aim of the study was to explore the question of how service users who are experiencing acute psychosis and mental health nurses deal with communicating together. This aim fits with Classic Grounded Theory methodology as it is open in its intent, yet specific enough that it is possible to develop a substantive theory (Glaser 1998, 2003). The study's initial objectives were to:

- I. Elicit accounts from mental health nurses and people who have experienced acute psychosis regarding their communication together.
- II. Derive a main concern shared by service users experiencing psychosis and nurses.
- III. Produce a substantive theory that accounts for how the shared main concern is resolved and/or managed.
- IV. Identify how the developed theory can inform professional knowledge and practice with regards to communicative processes between service users experiencing acute psychosis and nurses, in order to inform the care of those who are experiencing acute psychosis within an Irish mental health care context.

4.3 Design and Procedures

The study and thesis were carried out over an eight-year period, from November 2007 to June 2015. It required gaining ethical approval from two research committees, negotiating access to two research sites; a mental health service and a voluntary organisation. In this study, the main sources of data were interviews with people who have experienced psychosis (along with one published biographical text), and had contact with nurses attached to mental health services, and mental health nurses.

4.3.1 Inclusion and Exclusion Criteria

Given the specific area of study a criteria-based selective sampling method was used, as follows:

Inclusion Criteria for Service Users

1. Persons 18 years or over
and
2. Persons who experienced an acute psychotic episode in the last five years and were in professional contact with a mental health nurse during that time. With regards to this study, 'an acute psychotic episode', encompasses anyone who fulfilled the DSM-5 (2013) criteria for psychosis (see Literature Review). However, see 'Exclusion Criteria for Service Users' below for some exclusion to this understanding.
3. Persons who were deemed by themselves to be in recovery but were experiencing some psychotic symptoms, and were also considered by the main investigator to be able to attend to one-to-one conversations (please refer to Ethical Struggles on page 102, regarding the process of including this group).

Inclusion Criteria for Nurses

1. Registered Psychiatric Nurses who had cared for people who were experiencing acute psychosis within the previous five years.

Exclusion Criteria for Service Users

1. Persons who were currently experiencing an acute psychosis episode, as they might not be in a position to give informed consent. This included those service users who were experiencing acute psychosis and currently residing in a mental health service in-patient unit/ward (see Restraints Placed on the Study page 96), clinicians who recommended certain service users to make contact with this researcher, and the researcher's own discretion (see Ethical Struggles page for an account of this process).
2. Persons who had experienced a psychotic disorder due to a general medical condition (A variety of general medical conditions may cause psychotic symptoms, including neurological conditions [e.g., neoplasms, cerebrovascular disease, Huntington's disease, multiple sclerosis, epilepsy, auditory or visual nerve injury or impairment, deafness, migraine, central nervous system infections], endocrine conditions [e.g. hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism], metabolic conditions [e.g. systemic lupus erythematosus]. People who experience acute psychosis due a general medical condition, apart from seeing a liaison psychiatrist in a general hospital or at an out-patient clinic, rarely

have direct and prolonged contact with a mental health nurse. However, there are some exceptions, such as when acute psychosis is attributed to the use of recreational/illegal drugs. Therefore, this cohort has been included in the study].

3. Persons with psychotic symptoms present in dementia of the Alzheimer's type as this disease causes memory loss and confusion, thereby compromising informed consent.

Exclusion Criteria for Nurses

1. Those who have not worked in a clinical context in the last five years.

A total of sixteen participants were recruited: nine service users, seven nurses and one published biographical text of someone who had experienced acute psychosis.

4.3.2 The Research Settings

The mental health service setting had a rural and urban catchment area. It provided a range of adult services, including community, in-patient, rehabilitation and acute day hospital services to a socially and economically varied population of approximately 140,000 (based on the Census 2011). The other research setting was Shine (formerly known as Schizophrenia Ireland), which provides a support service for people experiencing serious mental health difficulties within the Republic of Ireland. The Shine organisation is divided into geographical regions, each comprising of support networks, and a Regional Development Officer. These officers provide information regarding: relevant and up to date information on local mental health services; information resources; training and employment services; other community resources; and organise and facilitate various support groups. Shine also provides an advocacy service that works with individuals on single or multiple issues which affect a member's life in the community. The research interviews generally occurred in available private space in the Mental Health Service Day Hospitals for most service users and nurses, while remaining participants who had experienced acute psychosis chose private space in a hotel or in Shine offices.

4.3.3 Gaining Access

Gaining permission to access sites and potential participants was organised in a number of ways. Initially, separate meetings were arranged with the Director of Nursing, and Clinical Director of the chosen Mental Health Service, and the Regional Development Officer for Shine. All were supportive of the proposed study and suggested ways of accessing potential participants. However, gaining access permission was provisional on obtaining ethical

approval from the relevant regional ethics committee. Therefore, this researcher had to apply for ethical approval (see Gaining Ethical Approval, page 94). Once ethical approval was obtained, it allowed the researcher to approach nurses and other clinicians to distribute leaflets about the study, inviting nurses and service users to make contact. Attendees of Shine were also approached.

The Shine Development Officer explained that while he supported the project, permission needed to be granted by each Shine support group; he committed to give a brief account of the proposed study and distribute my information leaflet (see Appendix A1 and A2) to the group. An invite was then extended to this researcher to attend a Shine support group based in the geographical catchment area of the mental health research setting, where the proposed study was discussed and teased out, in particular in relation to confidentiality, possible benefits, time required and interview locations. The proposal was also sent to the National Director of Shine, asking for it to be distributed to other Development Officers nationwide. One other support group extended an invitation to present and discuss the proposed study to them. At these meeting, attendees felt that the study could be beneficial, especially if it helped to improve nurses' competencies in how they communicated with them when they were experiencing psychosis. Thus, while at one level gaining access required permission from the Shine organisation, it was the support group members who made decisions on gaining access to their groups or not.

4.3.4 Participant Recruitment

A number of recruitment strategies were used to recruit participants for the study: five service users volunteered through direct invitation by clinicians working in the mental health research site; three were recruited following presentations at Shine support meetings; one service user made direct contact with the researcher after hearing about the project by word of mouth; poster invitations displayed in nursing stations yielded three nurse participants; and direct contact with potential nursing participants yielded another four. With regards to potential service user participants, if they indicated to a mental health clinician that they were either interested in finding out more about, or wanted to participate in the study, they were given the researcher's telephone number. Also some service users learned about the study from their peers and then made contact by telephone. Nurse participants obtained the researcher's contact number from the poster invitation or by direct contact. All participants were offered an initial meeting to discuss the research in more detail, and given detailed

information about the nature and purpose of the study. Potential participants also read an Information Leaflet (see Appendix A1 (p.229) and A2 (p.232)) and signed a Consent Form prior to interview (see Appendix B (p.234)).

A published biographical text of someone who have experience psychosis, and had contact with professionals attached to a mental health service was also used (Norwood 2007). This material was used during the de-limiting process of theoretical sampling. (See the section on theoretical sampling below).

4.3.5 Participant Profiles

The profiles of the participants are outlined below, however for the sake of clarity the profile of nurses and people who experienced psychosis are separately outlined.

Nurse interviewees were registered psychiatric nurses and their average age was thirty years (range 26-49). At the time of the interview two of the older interviewees held a certificate in psychiatric nursing, four held diplomas and one had attained a master's degree. When interviewed they were employed as:

Figure 1.

Staff Nurse	4
Clinical Nurse Management Grade	1
Community Mental Health Nurse	1
Clinical Placement Coordinator	1

All had experience working in various clinical settings, such as community, day hospital, admission unit, and long stay residential houses in the community. In the mental health service research site, there was a rotational system where nurses worked in a clinical location for about two years, then moved to another ward or clinical position. There was also a rotational system between day and night duties. In addition, staff nurses could be moved on a daily basis to fill in for holiday or sick leave. This practice of being moved at short notice mainly applied to junior and male staff nurses. Therefore, all nursing participants reported that they had contact with service users experiencing acute psychosis within the last five years and in multiple settings.

Service user participants' average age was thirty seven years (range 24-55). Their geographical backgrounds included those who resided in rural and urban areas. All service user participants were living within the community. In terms of educational attainment, employment and involvement with mental health services:

Figure 2.

Completed Leaving Certificate	6	Returned to third level as a mature student	1
Attended Third Level Education	5	Did not finish Third level course	2
Experienced Employment at some point	9	Currently in regular employment	1
Attending sheltered employment schemes	2		
Currently attending a Mental Health Service	8	Taking Anti-Psychotic Medication	8
Experienced Hospital Admissions	8	Had less than four admissions	3
Had between 4-18 admissions	5	In accommodation provided by a homeless voluntary organisation	1
Living with Parents	5	Living in a residential home owned by a mental health service	2

To protect participants' anonymity and for the sake of clarity nurse and service user participants will be numbered in order of being interviewed and will appear as follows: Nurse 1, Service User 1,...

Although deemed by mental health professionals to be not currently psychotic, some service user participants revealed that they continued to 'hear voices' on an ongoing or intermittent basis, and/or felt suspicious/paranoid, and lead somewhat chaotic lifestyles. This implied that despite apparent symptoms of 'unwellness' these participants were able to engage in the process of giving informed consent and were willing and able to hold relevant conversations for at least 45 minutes (See Ethical Struggles for a more in-depth discussion, see page 102. which includes a rationale and process of including these participants).

The published biographical text used comprise of one account of person who had experienced in-patient psychiatric care in 'Experiences of Mental Health In-patient Care' (Hardcastle et al. 2007). The criteria used for selecting these texts were that they had experienced psychosis and been in contact with a mental health nurse.

4.3.6 Data Collection

The interviews conducted in the study were similar in nature to the style of ‘intensive interviewing’ as described by Charmaz (2006). As previously noted, this approach was used as this researcher was not experienced in note-taking for interviews. Intensive interviewing is where the interviewer facilitates an in-depth exploration of particular topics by allowing the interviewees to describe and reflect on their experiences in ways they rarely get to avail of in everyday life. In these conversations the participant does most of the talking, and the researcher listens actively; with sensitivity, and encourages the person to elaborate through verbal and non-verbal communication. However, it is a conversation with a purpose: to elicit the participant’s views on particular issues. As far as possible, interviews were conducted at a place and time of the participant’s choosing but always in a quiet, private location. Service user participants usually chose HSE office space, while others preferred a private space at a hotel. Nursing participants chose HSE office space, either a Day Hospital or their work place. The interviews lasted from 40 – 90 minutes. Please see Appendix C for Interview Topic Guide (p.236).

4.3.7 Some Reflections on the Interviews

It was noted that some nurses initially appeared to give what Glaser (1998) called properline data; where interviewees responded by providing information that they thought they should give. They often asked if what they were saying was okay, while some adopted quite a formal way of answering, reminding the researcher of how interviewees might respond to questions in a job interview. This particularly occurred during the initial stage of the interview; however, as the interviews progressed and they experienced the researcher as being interested in their views, they visibly relaxed. Hence, they seemed to give more thoughtful answers. For example, when interviewing Nurse 2, early in the interview, I asked open questions about his views on interacting with service users in acute psychosis. This interviewee spoke about what would usually happen when someone in acute psychosis was being admitted to hospital. He recalled interacting with persons who could possibly show a lot of anger and aggression, and the need to follow certain safety procedures, which reduced the focus on talking with service users:

‘Well then, you have to have your team ready, you will have your team at the ready, you will explain to the patient exactly the procedures, why everybody is there, what's going to happen’.

Here, he focused on detailing accepted local procedures regarding risk management, talking with the style of one trying to give the ‘proper’ answer. Later, he seemed more relaxed and spoke more openly about his views on talking with service users; this is referred to as ‘baseline’ data; the best description a participant can offer (Glaser, 1998). However, it is important to note that one set of data is not considered more superior or useful than the other, as according to Glaser (2007), all is data, which means that whatever is going on in the research scene is relevant for conceptualisation. Hence, although ‘properline’ data is ‘data’ that informs the researcher something about what is going on in the substantive area, is considered more useful if the interview consists of different data as well.

It was also noted throughout interviewing that most service user participants’ focus was on telling the story of the trajectory of their mental health difficulties, communications with nurses, impact of psychosis and the diagnosis, their experiences of taking medication and hospitalisation, and living in their communities. It was judged important for them to be given this space, not only to make a connection with the interviewer, but for their story to be heard. This issue is expanded further under ‘Ethical Considerations’, page 100.

4.3.8 Tape Recording the Interviews

Glaser maintains that complete recording and transcribing of interviews is not necessary, as one is not looking for “descriptive completeness” (1998, p.107), but data that will assist in conceptualisation. He considers that writing notes during the interview and memoing are more effective than taping and transcribing. However, due to his training and experience Glaser is quite skilled in writing notes directly after interviews. Stern (2007) and Cone and Artinian (2009) also advocate this approach rather than tape recording. However, both acknowledge that for those inexperienced in research note taking, tape recording and transcribing is an option, therefore, there are times when the researcher can interpret classic grounded theory with flexibility depending on the research context. Thus, given the researcher’s own limited experience in taking notes, a decision to tape record all the interviews was made, however on one occasion notes were taken during the interview as the tape recorder failed to work. These tape recordings were then concurrently transcribed, coded, with field notes written on the same day as the interview. This allowed this researcher to recall the non-verbal communication that accompanied a particular segment of audio tape.

On reflection Glaser’s (1998) view of complete tape recording of interviews is not necessary carries a lot of merit; as transcribing is quite time consuming. However, within other

Grounded Theory approaches there are those who support taping interviews as well as the taking of field notes (Corbin and Strauss, 2008; Charmaz, 2006). One advantage of using an audio taping is that it allows the interviewer to engage fully with the participant, and assisted with the development of rapport between the participant and researcher. It also facilitated the exploration of more detailed data, in addition to noting in vivo concepts.

4.4 Sampling Method

In keeping with CGT methodology, there were no pre-set limits on the number of interviews required for this study, as well as gathering other data where relevant, such as written personal accounts relevant to the area under study. The rationale for not predicting the sample size is because it is not possible to pre-determine the quality or quantity of data required for theoretical saturation. Initially, two participants from each group (service user and nurse) were interviewed regarding their main concern about communicating with each other.

Once the study got underway, further theoretically based sampling occurred as questions and patterns in the data emerged. It is also important to note that the researcher has to be theoretically sensitive to be able to generate concepts from the data, by having an ability to maintain analytic distance from the data and tolerate confusion during the research process, and trust in preconscious processing for conceptual emergence (Holton 2007).

Generally, CGT studies can either focus on a particular issues pertaining to a homogeneous group, for example, socialisation of student nurses (Olesen and Whittaker 1968), people with cancer (Thompson and Artinian, 2009), suicidality amongst young men (Gordon, Cutcliffe and Stevenson, 2011), or a study that looks at different groups, such as *Awareness Of Dying* (Glaser and Strauss 1965). Considering the chosen area of study - communication patterns between service users experiencing acute psychosis and mental health nurses, it was considered more fruitful and respectful that both nurses and people who had experienced acute psychosis be interviewed, not just one group. Hence, a joint main concern and core category that spanned the two groups had to be identified and developed. Notwithstanding the extra complications that this might pose, this researcher maintains that including the two different groups was necessary in order to ascertain both parties' views on communications between them. It also complied with CGT's views on sampling; the participants should be easily accessible and knowledgeable about the phenomenon under study, in order to achieve a more comprehensive theory (Glaser 1998). Therefore, the participants must be 'experts'

about the research area in question; there is no doubt that it was possible that these two cohorts could provide such expertise.

4.5 Data Analysis: Generating the Theory

The procedures followed for data gathering and analysis in this study followed guidelines established for conducting a CGT study, which included selective and theoretical sampling. Selective sampling meant engaging with service users who had experienced acute psychosis and had communications with nurses, and nurses who had communication with service users, in order to ascertain their first-hand accounts. This was considered appropriate in order to gain some understandings of communication patterns between them.

Data analysis commenced immediately after the first interview. As already mentioned, interviews were tape recorded, verbatim transcripts were made by the researcher of all interviews and any personal identifiers removed. At this stage of the analysis a concurrent process of reading and analysing occurred which allowed the researcher to recall non-verbal nuances that could impact on the possible meaning of a statement, hence reducing possible misinterpretations.

4.5.1 Open Coding

Open coding was the first stage of the analysis, which according to Charmaz (2006), is the process of defining what the data is about. It was conducted in the first four interviews and provided “a point of departure” (Charmaz 2006, p.100). Here coding of the data occurred and questions were asked of the data where indicators for a tentative main concern and a core category were sought through data coding, conceptualisation and the comparative method (Holton 2007; Glaser 1998, 1978). When coding, action verbs (gerunds) were used, which helped the researcher to detect processes that stay close to the data. It assisted in getting a strong sense of action and progression relating to the studied area (Charmaz 2006). It also helped the researcher to move from description to conceptualisation.

Upon commencing open coding, Glaser’s (1998) advice about reading the transcripts line by line and coding was followed. However, despite the above guidelines, this researcher found the process of open coding in the early stages quite confusing and frustrating, as it resulted in over 180 codes with an accompanying desire to put some order on them by naming some of the categories with codes with professionally laden concepts. This researcher was worried that something important would be missed. It occurred as the term ‘line by line’ coding was

literally interpreted, rather than coding incidents. Here, the ‘incident’ is the unit of analysis – it is not the people, it focuses on people’s behaviour and picks up patterns. I had doubted Glaser’s (1998) assertion that if an issue was significant in terms of theory, it would reappear at a later point.

In addition, putting the researcher’s own preconceived ideas or biases on codes ran the risk of what Barney Glaser referred to as, ‘forcing the data’, rather than remaining open to naming the codes that relate to participants’ data, unless the researcher’s preconceived ideas are relevant and codes have “emergent fit” (Glaser 1998, p.81). For example, the ‘in vivo’ code *digging too deep* is an incident which gives a sense of a worry nurses experience regarding the possibility of making things worse for the service users when communicating with them that was relevant and had emergent fit. The process entailed putting trust in the method through repeatedly asking myself: What is this a study of? What categories does this incident indicate? What property of what category does this incident indicate? (Glaser 1998, p. 123). As well as coding for incidents, using the constant comparison method, theoretical sampling and memoing helped to get through this confusion and frustration (see examples of open coding in Appendix D (p.237). In addition, heeding Holton’s (2007) advice of being patient, staying with the process while striving for higher levels of concepts in the naming of codes also helped. See Appendix E1 (p.241) and E2 (p.247) for examples of how initial open coding was raised to higher level concepts.

4.5.2 Process of Identifying the Main Concern

According to Glaser (2005), if a researcher does not conceptualise participants’ main concerns it become difficult to discover the core category. As the study proceeded, a main concern began to emerge through constant comparison, selective sampling and writing memos which established the processes participants used to resolve their main concern.

The identification of the participants’ main concern was somewhat complex as there were two distinct groups included in the study. The issue was to get a main concern that encompassed both groups because at times what seemed like a main concern only applied to one group. For example, at one point it appeared that the main concern was centred on the psychosocial process of *being silenced*; in relation to what could and could not be said in conversation. However, this proposed main concern did not pattern out as it mainly applied to service users. Later, possible main concern that spanned all groups was identified as, *avoiding possible dire consequences when conversing with each other*, but it also did not

seem to fit. However, it was through using the process of CGT which includes asking ‘what is the participants’ main concern?’ and ‘how do they resolve their concern?’ of myself that this researcher was able to conceptualise the main concern that had a fit for both groups.

4.5.3 The Process of Identifying the Core Category

As the study preceded a core category began to emerge through constant comparison and selective sampling of the processes participants used to resolve their main concern (Glaser 2003). The core category (sometimes referred to as the core variable) can be any theoretical code and appears to explain how the main concern of the participants is constantly processed or resolved. It is the highest conceptual level and relates to all other concepts. It becomes the focus of further selective data collection and coding. Interviewees were invited to share issues that seemed important to them in relation to communications between service users and nurses. Theoretical sampling involved one-to-one interviews and facilitated more in-depth processes that give rise to the core category. According to Glaser (1998, p.115), “understanding and accounting for these actions from the perspective of the participants in the substantive area under study”, is what defines grounded theory.

Therefore, the core category’s main function is to integrate the theory by making it dense and saturated. Although the above might appear a straight forward process, identifying the core category was also not a straight forward process as frequently people are not aware of their latent patterns of behaviour and it takes time for their concerns and the core category to emerge, hence, it took a period of time for it to be identified. It emerged as a result of adhering to the constant comparative method: theoretical sampling, memo writing, using mind maps, sorting and preconscious processing. This was followed by trying to pattern it out. Some tentative core categories were ‘walking the line of permissible talk’, ‘negotiating permissibility’ and ‘guarded openness’. It was only after interviewing ten participants that the core category that involved guardedness met with CGT’s criteria of constantly recurring in the data, has the most explanatory power, and integrates all other categories. See Appendix F 1 (p.257), 2 (p.259) and 3 (p.262) regarding theoretical memos relating to the development of the core category.

Identifying gaps in the developing theory also led to interviewing different cohorts of service users and nurses about emergent issues of concern and their resolution, such as a gender, and context (community and in-patient). To elaborate the above examples, a service user participant identified finding it easier to talk with female nurses than male nurses. However,

theoretical sampling on this issue did not result in a category, as other participants did not consider the nurse's gender an issue when choosing a nurse to talk to. The second example refers to the context in which the conversations occurred. Some nurse participants had reported that they viewed the service user differently once they had met in his/her own home, as this influenced their conversations. As a consequence, data around different aspects of the context of conversations between the two groups were explored. As already outlined, this data was then coded and saturated by looking for comparison groups. In addition, some biographical texts of people who experienced psychosis were also used as part of the theoretical sampling process. Relevant parts were identified and integrated using CGT procedures.

4.5.4 Theoretical Saturation

Theoretical saturation occurs when no additional data is found to further develop properties of a category (Glaser and Strauss 1967). The researcher stopped data collection after the sixteenth interview, as few changes were made since the fourteenth interview. However, the researcher was cognisant that maybe if he continued, more interviews might yield a new property of a concept, but it appeared that those concepts that were developed had reached saturation point so a decision was made to cease data collection.

4.5.5 Theoretical Memos

Throughout the research, memos were written. Memos are memorandums of what the researcher thinks about the coded data that seemed to cluster together (Stern, 2007). They are the essential step between the collections of data and writing drafts of the theory, as they help to analyse the data and codes from the beginning of the process, in that they capture and keep track of the emergent theory.

Memos were initially hand written with a sense of 'free writing'; writing quickly with an emphasis of putting ideas into paper, rather than adhering to any formal writing style or grammar. These memos were later transcribed to computer files and expanded on. At the outset, I transcribed the interviews in one column, coded the data in an adjacent column and wrote brief memos as a footnote note at the bottom of the page (see an example in Appendix D (p.237)). Putting my thoughts on paper helped as it made the data more manageable: gave a space for articulating comparisons between: indicators and indicators; indicators and codes; codes and other codes; and codes and categories. It also helped to develop my analytic ideas, and indicated where I should go next to gather the next tranche of data, such as, theoretical

questions that needed exploration, and process decisions. I also carried a note book that recorded my ideas about the particular parts of the study that I happened to be involved in. Glaser (1998, p.178) calls this “preconscious processing”; ideas that occur seemingly at random but are as a result of one’s mind continually processing the data. These reflections/ideas were later expanded on or added to an existing memo. The process of memoing also helped manage my own biases creeping into the analysis without any obvious fit, as writing memos while constantly comparing, articulated what had emerged, fitted and relevant. For example, at one point I thought a category was ‘losing voice’, which referred to how participants felt silenced by the mental health service customs and practices. However, in the process of writing a memo on the above issue it became obvious that this did not fit, in addition to it not patterning out.

It is also important to note that participant service users’ and nurses’ quotes will be used in Chapters 5, 6 and 7 in order to illustrate the theory emerging from the data, so as to enhance its readability, and to offer the reader a way to access the depth of feelings about certain issues.

4.6 Ethical Considerations

The Concise Oxford Dictionary defines ethics as "moral principles" (1992, p.401). It was noted that the terms ethics and morals, are used interchangeably in discussions about ethical research. Robson (2002) separates the two by understanding ethics as the general guidelines and procedures of what a researcher should do, while morals refer to whether a certain act is consistent with the accepted view of right and wrong. Hence, ethical principles have been devised by various research ethics committees in health and education settings to guide researchers. The following are the ethical issues that applied to this study.

4.6.1 Gaining Ethical Approval

Ethical approval was obtained from the relevant HSE Regional Ethics Committee, and Dublin City University, to carry out this research.

The HSE research committee procedures require that the research proposal be submitted to the committee in advance of meeting with them. Some committee members expressed concern that those who have experienced psychosis may remember very little of the period when they were unwell due to the illness itself, and the prescribed medication, and that, therefore, the information that this researcher would obtain in interviews was likely to be

confabulated. Here, the validity of the study was being questioned with the suggestion that service users experiencing psychosis cannot give a 'true' account of their conversations with nurses due to memory loss. Therefore, talking to service users would not produce any useful results. However, it was argued by this researcher that while there is some evidence that both the psychotic experience and the taking of anti-psychotic medication can disrupt one's concentration and memory (Sadock, Sadock and Ruiz 2009), there is ample evidence that service users recount aspects of their interactions with professionals that carry significance for them. For example, there are many published accounts from people who have experienced psychosis about their experiences, which include their interaction with health professionals, family and friends (Hardcastle et al. 2007). In addition, from the researcher's own professional experience as a clinician, people who have experienced acute psychosis recall many events from that time. This was borne out in this study, for example, a service user remembered his fear and sense of abandonment watching his mother leave the ward after he was admitted involuntarily for the first time. Another recalled a sense of "not being listened to", with the professional involved appearing being more interested in checking for signs and symptoms of illness, rather than his engaging with him about his worries and concerns. The committee accepted these points and granted ethical approval.

Gaining ethical approval also involved demonstrating to both ethical committees that the researcher has considered and put in place certain safeguards that will protect research participants, the researcher and the research context from harm. Safeguards pertaining to this study are outlined below. As this research study involved interviewing two distinct groups of participants, some of these safeguards were more relevant to one group rather than the other. There has been some debate regarding the usefulness or otherwise of the requirements of ethics committees in relation to qualitative research as generally these committees draw largely on a medical and quantitative tradition (Cutcliffe & Ramcharan 2001; Ramcharan and Cutcliffe 2001). The debate centres on ethics committees having to make decisions about the ethics of a particular research proposal before the research takes place, and very few actively monitor any ethical issues once the study commences. Hence, these decisions can be difficult to judge, decisions such as accurately balancing the risks and benefits of a proposed research project, as not all questions can be known beforehand. This is particularly true of a CGT study, in which the substantive area being researched is known, as one has to remain open to emerging issues and cannot construct definitive questions to guide the initial interview(s). That said, apart from the safeguards being a requirement of the ethics committees, this

researcher believes that overall they are a useful guide, not only to myself, but also to others to help ensure that potential risks and benefits to participants of this research have been carefully considered.

4.6.2 Restraints Placed on the Study

A restraint placed on the study was that the researcher could not interview service users experiencing acute psychosis who were currently in-patients in the mental health service research site or observe nurse – service user interactions within this context. This restraint was placed by the mental health service research site who believed that this cohort of service users were very likely to be unable to give informed consent to participate in the study. It is true that historically the biomedical approach considered that those with a diagnosis of an acute psychosis were lost to their illness and had difficulty making decisions about their care (Davidson 2003), which resulted in exclusion from being offered the chance to make informed decisions about being involved in research. However, Helm, Heggen and Ruyter (2007) argue that this approach makes research with these service users impossible as they are deemed too vulnerable to engage in a research process. They maintain that by inserting an experienced researcher and mental health clinician into the therapeutic milieu of the in-patient unit he/she has the ability to respect the service user's vulnerability when they have (to varying extents) a flawed understanding of reality. Yet, service users with psychosis also interact with other service users, clinicians, family members and others, and apart from their mental health difficulties are also humorous, express their opinions, and keen to understand what is occurring for them (Bidois 2012; Johnson 2012). So, they have strengths and vulnerabilities and by excluding them from the opportunity of making an 'informed decision' about being involved or not is somewhat arbitrary. Indeed it could be argued that it not only deprives and devalues them, it deprives and devalues the service and clinicians from gaining knowledge of the service users' voices and what is occurring for both nurses and service users in this area of practice. However, the researcher had to abide by this directive in order to obtain consent for the study to proceed. Therefore, it was decided to focus on service users who were living in the community and had experienced an acute psychotic episode within the last five years, and nurses who had cared for service users that were experiencing acute psychosis.

4.6.3 Providing 'Safety Measures' for the Participants and Researcher

Research with those considered to be vulnerable people requires careful consideration; people who attend mental health service are deemed to fit into this category (Robson 2002; Liamputtong 2007). Therefore, during the interview process, the researcher was cognisant of the possible impact of the interview process on service user participants in particular. Therefore, the following process was adhered to:

- Interviews were conducted by this researcher who is an experienced clinician, who has over twenty years experience both as a nurse and psychotherapist, and who is trained to make clinical judgements about risk levels and appropriate responses to same, thereby being in a position to assist in reducing the risk of distress for service user participants.
- Participants were informed of the limits of confidentiality; if they were deemed an acute risk of causing harm to self or others, revealed serious professional misconduct, and/or were judged currently acutely psychotic, the researcher would then take appropriate action. For example, a service user's treatment team would be informed in a timely manner. If not currently attending a mental health practitioner, they would be advised to make contact with their G.P. and to arrange an appointment with their local service. If a nurse revealed serious professional misconduct this would have to be reported to their professional body.
- If necessary appropriate detailed information will be provided to participants informing them about support structures, statutory, non-statutory and self-help agencies, with which he/she could choose to, or be advised to, engage in.
- Participants retained overall control within the interview regarding the nature and level of material shared.

While the above safeguards mainly refer to service user participants, it does not mean that the researcher was not conscious of the possible impact of the interview process on nurses, as being interviewed can result in all participants potentially feeling vulnerable, especially if a sensitive topic was discussed. However, it was judged that on balance service users were more likely to have experienced traumatic events in their lives, such as hospitalisation, and psychotic symptoms.

In addition to the above, the interviewer constantly gauged how the process was unfolding during the interview and if necessary checked in with the interviewee. The researcher also created a debriefing space at the end of each interview for the participant to reflect on the interview process.

One service user participant said that the experience of talking about his hospital admissions was a little upsetting, as he had regrets about leaving hospital prematurely on his first admission because he quickly relapsed. However, he then reflected that maybe he was not ready to accept help at that time, but he was more open to it later on.

Some nurses commented that being interviewed helped them reflect on the way they interact with service users experiencing acute psychosis:

'I never thought about it before, it's made me question taken for granted practices'.

Participants, in the main, hoped that their interview would assist in developing more useful ways for nurses to communicate to services users. Hence, the provision of this space at the end of the interview was useful for the participants and the researcher.

4.6.4 Informed Consent

Study participants need to fully appreciate what they are getting into so they can give informed consent (Williamson 2007). Participants were given an Information Leaflet if they expressed an interest in participating in the research. An initial meeting was offered to potential participants where the research project was explained in more detail and questions were answered. It was also made clear to the potential participants that the interview would be audio taped. However, if they objected to this method of recording the researcher would take notes. In addition, these recordings would be listened to only by this researcher, and kept in a secure location; these tapes will be destroyed once the thesis is accepted. Throughout the meeting I was explicit regarding what the research was about and the rationale for the study was discussed, including why it was being carried out and what it might achieve. At all times it was made explicit that he/she was free to choose to participate or not. The potential participants either agreed to take part in the meeting itself, or later by making telephone contact. If they agreed to take part, all participants at the start of the research interviews read and signed a consent form (see Appendix B (p.234)).

With regards to informed consent, the approach advocated by Cutcliffe and Ramcharan (2001) was also employed during this research. This approach states that qualitative research involving interviews with potentially vulnerable people is better suited to the 'ethics as process' approach, requiring ongoing consenting and the ongoing option to withdraw. However, it was explained to them that it would be difficult to withdraw their material once it was coded and integrated into the theory. No study participant withdrew his/her consent.

4.6.5 *Maintenance of Dignity*

Each participant retained overall control within the research interview, while understanding that the researcher was interested in certain topics. The participants set the boundaries of how much they would share and the depth they were willing to explore, of when and where the interview occurred, and how long the interview lasted. For example, some service user participants stated that they were not willing to discuss the circumstances of their admission or content of their worries/symptoms, which was respected by the interviewer.

4.6.6 *Risk to Benefit Ratio*

Ethical issues in this area are concerned with judging the potential benefits, either to the individual or to society, against the possibility of harm to the subject (Johnson 2007). In this study some of the research participants were drawn from what is seen as a 'vulnerable group', that is, they are more vulnerable than others to exploitation if engaging in a research study. Service user participants had experienced a psychotic episode in the last five years, so their risks were potentially greater. It was also important to be cognisant of the fact that this participant cohort varied in their experience of psychosis and its personal impact. Therefore, it was important that the researcher was aware that interviews could be stressful for some participants, and their possible impact on people with psychosis, as excessive stress can be an influential factor in relapse from the view point of vulnerability-stress models of schizophrenia (Nuechterlein and Dawson 1994; Anthony and Liberman 1986). Therefore, if a service user became overly distressed or upset the research interview would be terminated and support and counselling would be offered to alleviate the distress or upset.

It must be noted that nurses could also become distressed when recounting emotionally upsetting events: events such as being assaulted or verbally abused in the course of their work, having a family member with psychosis, or personally experiencing mental ill health. One nurse spoke about his upset at seeing a service user he had visited as a community nurse in her home being put into a seclusion room, when he considered that talking to her about

trying to abscond would be more beneficial. His upset also encompassed regrets at not putting his point of view across in a more forceful way, but as a junior staff nurse he felt unsure of his authority.

Some authors have questioned the ethics and suitability of researching vulnerable groups, including those with severe mental illness (Moyle 2002; Usher and Holmes 1997). Furthermore, a particular topic or issue that carries significant negative emotion may only become apparent as the study progresses (Scharer 1996).

There are five main situations where research could be threatening (Owen 2001; Gibson 1996; Lee 1993). These are where:

- The research poses an ‘intrusive threat’ to participants because it concentrates on topics that are sacred, private or which provoke fear
- Information is provided in the study that can be stigmatising or incriminating
- Participants are drawn from vulnerable groups who are open to exploitation
- There are political implications from the findings, which may lead to controversy
- There is an inherent risk to the researcher in carrying out the study

The first four points are more relevant to research with people with psychosis. Therefore, it was important that the researcher had awareness of carrying out research in a sensitive area, which carried responsibilities to all participants. The last point has some relevance to all research and the level of judged risk could be greater in some projects over others. This researcher judged his personal risk level as relatively low relating to this research project, as all participants had agreed to partake in the study; we had already discussed any potential worries and concerns at the information meeting; and because of my experience in being involved in clinical conversations with individuals, couples and families over many years, and being able to recognise and de-escalate difficult situations.

There is ample evidence to suggest that most interview participants benefit from having someone listen to their stories in qualitative interviews (Murray 2003; Kavanaugh and Ayres 1998; Patton 1990). By telling their own stories, participants can begin the process of making sense of what has happened to them, which helps their recovery or professional practice. Therefore, a balance has to be maintained between the risk to participants and the benefits of having someone listening to their stories. Also, by identifying current needs, service users

could engage or re-engage with support structures and treatment services as indicated. Indirect benefits include development of principles that will inform professional practice, and service provision relating to the care of people who are experiencing acute psychosis.

4.6.7 Anonymity and Confidentiality

This refers to how the details about participants' involvement are protected. Anonymity of participants and confidentiality of interview material was safeguarded through a number of measures, including the following:

- Tape recorded materials were kept by the researcher in a locked filing cabinet in a secure location
- Only the researcher had access to this material, as it assisted him with directing the project in the most useful way on the basis of emerging issues
- Signed consent forms were stored by the researcher in a locked filing cabinet, in a secure location and did not carry any identifying codes that connected individuals to specific recorded data
- No information identifying an individual person was used in documentation pertaining to the study
- All material relating to the study in line with ethics approval will be destroyed once the thesis is accepted

However, study material is subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim, and my own obligations in case of the possibilities for harm.

In addition, the identity of the participants in the research was not identifiable in any way. Their names, ages, addresses, the health service, and any professionals that they attend, and names of any work colleagues, were changed. Also, when the participants spoke about the professionals that they were involved with, colleagues or other patients this researcher has changed all their titles to 'Nurse' except in the interest of clarity. Data is shared in as direct quotes from interviews but in an anonymised way.

4.7 Ethical Struggles

An ethical issue that this researcher encountered was that some service users revealed, either in the information meeting or the interview itself that they were currently experiencing some

symptoms of psychosis, such as hearing voices or feelings of paranoia. The dilemma centred on the project interviewing people who 'had' experienced acute psychosis, yet here were potential participants or participants that were currently experiencing some symptoms. The question of their ability to give informed consent was relevant. This dilemma was discussed with my research supervisor and the Clinical Director of the mental health research site. It was decided that considering that this researcher is an experienced mental health clinician I would make a judgement on accepting the person for interview or continuing the interview. For example, if it appeared that their ability to make an informed decision was seriously compromised the interview would be postponed or stopped. However, it could proceed at later point if the service user so wished. As service users' personal experiences are important in planning and providing mental health services (Neil et al. 2013), it was deemed advantageous to include those that were experiencing some psychotic symptoms and were able to give informed consent. In particular, if during the information session or at interview the service user participant was able to concentrate on and take part in the discussion, she/he understood its import, and was managing their lives in a 'good enough way'.

All service user participants were deemed well enough to partake in the study and all were keen to do so. One service user was experiencing hearing voices since the age of five and was not attending a mental health service. Yet, she was managing these voices without medication, attending college and doing well both academically and socially

4.8 Summary

This CGT study was carried out over a seven year period and involved interviewing seventeen participants. Nine were services users who had experienced acute psychotic episode(s) of varying and severity and duration. Seven mental health nurses who had experience working in both in-patient and community settings. All had experience of communicating with the other group, which including its quality, purpose and felt apprehensions. A number of methodological and ethical challenges were identified during the study. The methodological challenges centred on using favoured codes that did not fit, which was identified by memoing, personal reflections and trusting in the Classic Grounded Theory method. The main ethical issues was recruiting and interviewing service users that reported they were having some psychotic experiences, which was resolved through discussions with the clinical director and academic supervisor where the researcher if needs be could make

informed decisions with a service user about being able to give informed consent and being involved in the research process.

Through adhering to the Classic Grounded Theory methods it enabled a substantive theory to emerge that is grounded in the data. As a result, the next three chapters describe the emergent theory, *guardedness in communications*, in detail. The following chapter will summarise the theory and next two will describe the sub-core categories.

Chapter 5. The Theory: Guardedness in Communications between People Experiencing Acute Psychosis and Mental Health Nurses

5.1 Introduction

The aim of the study was to develop a theory that would explain how this cohort of service users and nurses deal with communicating with each other, which could be utilized to inform professional practice within mental health services. Classic Grounded Theory maintains that latent patterns occur within social and psychological contexts, which can be recognised, conceptualised and theorised (Simmons 2011). Before a study commences these patterns are not known but will emerge as the study progresses. Initially the researcher identifies the main concern of the study participants. Once ascertained the focus is on the processes that the participants engage with to continually process or resolve this concern, which is captured in the core category. This chapter provides an overview of these patterns by briefly outlining both the main concern and core category that emerged in this study.

5.2 The Main Concern: *Establishing Permissible Communications*

The main concern or the core issue of participants regarding the area of exploration was identified in the initial stage of the study where participants were invited to speak about their perspective on communicating with each other, what they considered positive and negative interactions, and the impact of psychosis, mental health service procedures and culture on their joint communications. The aim at this stage of the analysis was to establish the main concern for both groups, which was conceptualised as '*establishing permissible communications*'. This refers to concerns about what is permissible to say and do when communicating together. For example, service user participants worried about being restricted if deemed to be unwell:

'You'd be careful about what you say. You could end up in seclusion if you told them you were not taking medication anymore. 'Like [medication] compliance is very big thing. If you start being non-compliant you end up staying longer, or being put in hospital where you end up in the seclusion room and being injected against your will.'

Nurses' concerns ranged from being judged as a poor nurse to causing the service user to become distressed or aggressive. A frequent worry that nurses expressed was that they would inadvertently say something that would make the service users psychotic experiences more severe.

'I suppose from the point of view if they're paranoid, because they could be paranoid towards you. So you have to be careful that you don't kind of... that you don't dig too deep. You know in the initial stages when they come in, if they are in an acute psychotic phase, it might reinforce their delusions.'

However, these concerns also posed a dilemma for participants, as they were uncertain about what communications were allowed or appropriate at a moment in time, yet they were regularly required to, or needed to, engage each other in conversation. In attempting to figure out what was permissible they were occupied with the question 'what is okay to say and do here?' A consequence of establishing the main concern allows the researcher to then examine the resolution process, in this instance 'how do participants deal with this issue of trying to establish what is permissible to say and do together?' which is explained in the core category.

Figure 3. The Key Components of the Main Concern

	Concepts	Main Concern
Nurses	<ul style="list-style-type: none"> • Valuing medication before communication • Fear of saying the wrong thing • Relying on using general reassurance • Not knowing what to say • Putting off more open conversations 	Establishing permissible communications
Service Users	<ul style="list-style-type: none"> • Fearing hospitalisation if they talked openly • Avoiding medication by not revealing psychotic experiences • Desire for talking help • Experiencing nurses avoiding conversations • Choosing nice nurses to talk too 	

5.3 The Core Category: *Guardedness in Communications*

The core category *guardedness in communication* is about using caution as a way to facilitate communication. The core category is the highest level concept of the theory and relates to as many other categories and their properties as possible and accounts for a large portion of the variation in a pattern of behaviour (Glaser 1998). See Figure 5 for a diagrammatic representation of the Core Category and Sub-Core Categories, from which the theory evolved. The core category emerged through data analysis which involved building higher level concepts, identifying patterns across the data, and ascertaining the relationships between categories. As more mature categories were recognised the core category emerged as *guardedness in communications*. Emergence of the core category does not mean that it

suddenly appears. It takes time and much coding and analysis to verify a core category through theoretical sampling and reaching a point of saturation (Glaser & Holton, 2004).

Guardedness in communication describes a psychosocial process where service users and nurses engage in an unconscious or mostly implicit complex interactive process that relates to a form of ‘caution’ that they engage with to work out together what is permissible to say and do together, thus making their communications safer and having some ownership and choice in what they communicate. Once an understanding of permissibility is ascertained, it does not stay fixed, as it is liable to change if either one’s sense of risk or safety increases/decreases, or if one or the other deems that it could be advantageous to change the mode of communication. Thus, *guardedness in communication* is always present within their communications where both impact on the degree of how much their guard is lowered or raised.

Figure 4. Core Category and Sub-Core Categories

Core Category	Sub-Core Category 1	Category
		Learning Guardedness
		Category
	Sub-Core Category 2	Experiencing Risk
		Category
		Keeping Conversations Light
Guardedness in Communications	Raising Guardedness	Category
		Developing Safety and Trust
		Category
	Lowering Guardedness	Conversing about Issues of Importance and Concern
		Category

Therefore, service users experiencing acute psychosis and nurses fluctuate between lowering and raising their guard with each other depending what is happening in a particular communicative episode, the context in which the communication is occurring and their internal dialogue.

5.4 Overview of the Theory: Guardedness in Communication between People Experiencing Acute Psychosis and Mental Health Nurses

The theory ‘Guardedness in Communication between People Experiencing Acute Psychosis and Mental Health Nurses’ captures the process that allows communications to be more secure and beneficial, through the instigation of appropriate levels of guardedness as both groups work out what is permissible to say and do together. This process has the flexibility to permit the altering of their understanding of permissibility if needs be. Hence, either can fluctuate between raising and lowering their guard, depending on what is judged most useful and necessary at a moment in time, thereby establishing ways to safeguard their sense of ownership over what issues are deemed important to share or withhold.

Figure 5 is a diagrammatical representation of the evolution of the theory. It is important to note that that in practice the relationship between all categories is neither hierarchical nor linear, but interactive and cyclical as each is influenced by the others.

Figure 5. Evolution of the Theory ‘Guardedness in Communications between Service Users Experiencing Acute Psychosis and Mental Health Nurses’.

Core Category	Sub-Core Category	Minor Category	Category	Properties
Guardedness In Communications	Raising Guardedness	Learning Guardedness	Becoming Guarded	Being ostracised/fearing ostracisation, acquiring apprehensions, digging too deep, discouraged to talk openly
			Learning Institutional Talk	Modelling, medication reliance, sharing stories, making judgments, enacting established communication patterns
		Experiencing Risk	Enacting Distrustfulness	Vigilant living, disbelieving the other, experiencing negative voices, creating distance, unpredictability
			Experiencing Hostility	Being confined, following protocols, judging risk, curiosity minimisation, protecting self
		Keeping Conversation Light	Using Re-assurance	Just saying enough, emphasizing safety and hope, playing for time, valuing medication, respectful listening
			Playing the Game	Concealing and revealing , uninterested in the other’s story, benefits in concealing, revealing by observation and talk
	Lowering Guardedness	Developing Safety And Trust	Making Connections	Burdensome living, assessing safety indicators, connecting to the other, showing curiosity
			Observing and timing – choosing a safe place to talk	Creating a safe enough space, giving time, showing willingness to talk, meeting regularly, judging when to talk
			Trusting the Other	Promise keeping, listening and responding, reliability, showing respect, matching the others verbal/non-verbal talk
		Conversing about Issues of Importance and Concern	Creating Joint Understandings	Enabling storytelling, being present, making sense, connecting to the other’s story, sharing psychotic experience, keeping communication door open, validating talking
			Easing Worries	Showing openness, focusing on areas of immediate concern, checking meanings, re-balancing power, normalising conversations, joint problem solving, valuing talk

5.5 Summary

This chapter outlines the main concern, core category and substantive theory which emerged from this study of how service users experiencing acute psychosis and nurses communicate together. The core category meets Glaser's (1998) criteria in that it constantly recurred in the data, and was the one category with the most explanatory power to integrate all other categories. Hence, *guardedness in communications* is a dynamic and fluid process that facilitates nurses and service users in establishing what constitutes permissible communications at any given time, where either can raise or lower their guardedness in their active communications with each other. This allows for ownership over what they say and do, which contributes to their sense of safety and autonomy. Thus, they are active participants in the construction of appropriate boundaries around their communications.

The next two chapters describe in detail the sub-core categories *Raising Guardedness* and *Lowering Guardedness*.

Chapter 6. Raising Guardedness

6.1 Introduction

This chapter describes in detail *raising guardedness*, a sub-core category of *guardedness in communications*. It explores some of the reasons why service users experiencing acute psychosis and nurses become more guarded when communicating together, and how they manage to communicate within this context.

6.2 Raising Guardedness

Raising guardedness refers to a process whereby participants formed, integrated and enacted understandings of what constituted risky communications and behaved to manage their joint communication in order to feel safe enough and gain a sense of ownership when conversing with each other. This process involves establishing what is permissible to say and do together at any moment in time by raising their guard.

How service user participants come to consider communicating with each other as risky has its roots in a socialisation process. Service users initially learn to raise their guard within their own communities, by discovering that talking openly about their worries or diagnosis is likely to result in some degree of ostracisation. Nurses' socialised guardedness happens within clinical mental health settings, in particular as a student and junior nurse. They learn that being too open is generally not useful as it might result in the psychosis becoming more severe or cause the service user distress who may then react aggressively. Hence, both learn that talking freely about psychotic experiences has the potential to cause serious problems. As a consequence, nurses and service users become guarded in their communications to avoid harm and promote positive possibilities.

Guardedness increases when they became suspicious about the other's motives or ability to hold reasoned conversations. This suspiciousness is used not only as a way to protect themselves from either causing or experiencing harm; it also provided a rationale to dismiss the other's perspective. As a consequence, a nurse could make decisions on behalf of service users, while service users could justify disbelieving that he/she was ill, thereby rejecting offered help.

Therefore, communications are kept brief and if possible, generalised. This is achieved through keeping their communications on the light side by offering and accepting general reassurances about specific worries or distress, asking specific questions that obtain short answers, telling the other what they think is advantageous or useful to hear, and adhering to prescribed treatment plans. This makes communicating together safer by being able to protect oneself and by having ownership over what is said and what is kept hidden.

This sub-core category is further explained by the categories: *learning guardedness*; *experiencing risk*; and *keeping conversations light*. See figure 6 below as a diagrammatic representation of the sub-core category *raising guardedness*.

Figure 6.

Raising Guardedness					
Learning Guardedness		Experiencing Risk		Keeping Conversations Light	
Becoming Guarded	Enacting Intuitional Communications	Enacting Distrustfulness	Experiencing Hostility	Using Re-assurances	Playing the Game

6.2.1 Learning Guardedness

Learning guardedness refers to how participants become apprehensive about communicating with each other. Experiencing communications as being risky does not suddenly occur upon initial contact; most already carry varying degrees of uneasiness, which influences how their initial joint interactions are approached. This uneasiness is based on what each believes it is permissible to say, which is formed through a process of learned socialised wariness regarding being unguarded about acute psychosis, both in the community and in in-patient mental health settings. This is described in more detail by *becoming guarded* and *learning institutional talk*.

Becoming Guarded

This category refers to how service users experiencing acute psychosis and nurses develop socialised wariness regarding talking unguardedly with each other about the psychotic experience before any interaction takes place between them.

Service users initially learn guardedness prior to any contact with nurses as they fear being ostracised by family, friends and others in their own community. They learn that by talking about their psychotic experiences, and/or being identified as carrying a diagnosis of psychosis or schizophrenia could carry a high personal cost, such as experiencing discrimination, or being admitted involuntarily to a psychiatric hospital/unit.

SU1 recalled his attempts to share his worries and experiences with friends and work colleagues:

'I have to say of all the people that I've met, before I went into hospital, the usual reaction would be, 'You're a bit paranoid, or that's not true, or you're completely mad'.'

I wondered who would say this to him:

'Other people like. People that I work with or I knew like, by just saying things like that to other people, my friends and that, they just didn't believe me.'

When asked how this affected him:

'They thought I was crazy, like. You know, you get that alright if you're suffering from delusions, like. Eventually, you'd probably not bother to say it to anyone.'

Becoming aware that others not only disbelieved him but placed his worries and by association, himself, into the realm of madness, influenced him to become guarded about revealing his experiences and thoughts. Hence, service user guardedness can be a result of being rejected, disbelieved, and seen as behaving outside of acceptable societal norms. In order to avoid these consequences, SU1 stopped sharing these concerns with friends and others in his community. However, while keeping his worries hidden offered him some protection, it did not ease them; instead he felt isolated, with his psychotic experiences becoming more severe:

'I gave up my job and stayed in my flat, but in hindsight that didn't help it just got worse.'

SU3 focused on the idea that people with a diagnosis of psychosis are considered unpredictable and dangerous:

'I think it [psychosis] scares people..., it can be linked up, to psychopaths, you know, like if you are suffering from psychosis you are a bad man, not just a bad man, you know am....., you know a bad and mad man...'

'It's like you are a mass murderer or an evil paedophile.'

His fear is that he would be seen as different, labelled as potentially dangerous and is therefore to be avoided, as psychosis is linked with other groups who are considered dangerous and undesirable. SU6 agreed that people with psychosis are viewed this way, both in their own community and society at large, as people tend to link the terms schizophrenia/psychosis with the words:

'Psycho, madman, and nutter.'

I wondered where she thought they learned to do this:

'From the media; the print and broadcast media. A lot of people think that people with psychosis are automatically dangerous..., and they are automatically the 'other'.'

'We are seen outside of the box, outside the community, we're on the fringes, you know.'

Hence, those experiencing psychosis are aware of the negative perceptions about those who people view those who carry these diagnoses; so if possible, they keep their diagnosis and experiences secret to avoid such consequences. SU3 was also aware that generally those with

a diagnosis of psychosis/schizophrenia are likely to experience discrimination, in particular in relation to employability status:

'You know if you go look for a job, and you've been out of work for a while and you are trying to fill in the blanks in your CV. You have to just put down depression rather than psychosis, because psychosis is like, you know you're on death row.'

Thus, keeping his diagnosis hidden is seen as necessary as gaining employment is important for his self-esteem and prospects of recovery. It also indicates that there are relatively different levels of diagnosis acceptability with employers, with depression being more acceptable than psychosis. SU1 also worried about the impact of receiving a diagnosis of psychosis and the ostracisation that might result from being objectified both by mental health professionals and the general public. She believed that objectification results in being seen just as a label rather than a person:

'Automatically I think it's sort of bracketing somebody and from my own experience I feel that when somebody gives me a certain diagnosis of a psychosis, they don't really understand the totality of me, so automatically my identity is completely wrapped up in psychosis.'

I asked about the impact of these worries:

'It can have an awful lot of repercussions when you're living in a community, you know. You are a member of a community and you suddenly feel in your head very ostracized from that. So that sort of perpetuates a feeling where you can't tell somebody, you know.'

Her apprehension about experiencing objectification encouraged her to become guarded about her diagnosis, as being viewed as a diagnosis, rather than someone who is experiencing psychosis, would diminish and limit her. These fears became so dominant that she kept her diagnosis secret for eight years, as the possible impact of the diagnostic label was more difficult than living with her secret. Hence, a choice was made to hide that part of her from family and friends, which provided a way of living somewhat safely within her own community. However, as above, the problem with this approach is that although it provides some protection against being ostracised, and her identity being compromised, it does not diminish her difficult experiences as it leads to delays and reluctance in seeking help.

Hence, service users learn to become guarded about talking openly regarding their worries and diagnosis in response to their experience of, or fear of, being ostracised, objectified and discriminated against by people in their community, family, friends or employers. These

responses limit and diminish their identity as a person. As a result, they enact a protective guardedness regarding revealing their experiences. Therefore, their struggles regarding lived experiences are not easily spoken about, and continue when they come into contact with nurses in mental health service settings.

Nurses learn to become guarded about communicating with service users experiencing acute psychosis early in their career, in particular, when they start working on in-patient units and mental health community facilities. This is not to say that they may have not already formed a negative view on the issue of mental illness before they train as a mental health nurse. Within mental health services, student nurses and junior staff generally work as part of a team of nurses, and other professionals. It is through observing and working with these colleagues that they begin to acquire apprehensions about communications with this patient group by learning from others what is and is not permissible.

N1 spoke about this issue when I enquired into where she learned how to talk to service users experiencing acute psychosis. She recalled her time as a student nurse working on various wards and carrying fears about interacting with these service users. She talked about lack of experience:

'Nurses would say that they [service users experiencing acute psychosis] were 'schizophrenic'. They would have a label on them. Then you would hear the terms hallucinations or delusions being used but as a student you would not really be sure what they meant. We learn all the theory, but we would not have been experienced enough to have learned from the patient, because you would nearly be afraid of the diagnosis. I was very unsure of it.'

As a student, N1 was uncertain how these psychotic experiences manifested, hence, she felt unable to identify them, and worried that she was unable to fulfil a nursing task. Part of her fear was being anxious about asking specific questions of senior staff regarding psychosis:

'I was nearly afraid to ask, 'what do you mean when you say that this guy is having hallucinations or delusions? What do they look like?' But I didn't as you were supposed to know all these things from college.'

This felt lack of approachability with more senior nurses increased her worry that they would make a judgement on her apparent lack of nursing knowledge and skill, which could diminish her standing as a nurse. As a result, she decided not to expose herself to possible criticism by becoming guarded about her knowledge deficits. However, this approach restricted access to

learning about how to communicate with service users, with a concurrent risk of increased apprehensions about talking with them. Ironically, she learned to mirror the service user response of concealment. N7 also recalled carrying similar worries about asking questions of senior staff, not because it was explicitly forbidden, but because this was not openly encouraged. However, implicit discouragement occurred by being excluded from nursing those with acute psychosis; it was seen as the preserve of senior staff:

'Well any admission [of service users experiencing acute psychosis] experience that I had as a student wasn't much really. It was senior staff who took care of these admissions. So really I didn't have much to do with these admissions.'

Not only were some students excluded from being involved in the admission procedure, according to N7 they had poor role models regarding how to communicate with service users experiencing psychosis:

'I remember when someone came in and they were very unwell, they medicated them and they were put into seclusion. I don't think there was much interaction there. I can't remember ever seeing anyone sitting down talking to these patients.'

Therefore, she observed colleagues medicating and putting service users into seclusion rooms rather than communicating with them. This lack of appropriate role models regarding communication induces a sense of uncertainty and nervousness for students and junior nurses about how to communicate, which was further reinforced by being actively encouraged to talk to patients with different diagnoses rather than those who were experiencing psychosis:

'I wonder why this happened. Talking to patients who deliberately self-harmed, personality disorders and those with depression sticks out in my mind. Maybe the students and newly qualified nurses for some reason got landed with these.'

Some students and junior nurses rely on implicitly learning what was permissible by observing and then attempting to model how senior nurses interact with service users. Considering the above, and in the absence of appropriate role models in relation to communicating with service users, nurses began to develop guardedness as it provided some protection against their apprehensions and uncertainty.

Another issue that influenced student and junior nurses to become guarded was when certain advice was given regarding what not to do when communicating with service users. One piece of advice that N5 stated was always highlighted as important is:

'Not to dig too deep when talking to psychotic patients.'

This refers to a belief that holding prolonged and/or in-depth conversations with service users experiencing psychosis increases the likelihood of their problems being exacerbated:

'I suppose from the point of view if they're paranoid, because they could be paranoid towards you. So you have to be careful that you don't kind of... If they are acutely psychotic, that you don't dig too deep. You know in the initial stages when they come in, if they are in an acute psychotic phase, it might reinforce their delusions.'

The possibility of re-enforcing a service user's symptoms is a major concern for nurses. Re-enforcing delusions is understood as validating and strengthening a service user's illness related beliefs or experiences, for example, confirming that they have special powers of healing or that they are the devil. This is considered likely to occur if a nurse engages in prolonged conversations about issues of concern identified by the service user. N3 remembered learning this rule:

'Senior nurses would tell you this as well as lecturers in college, not to reinforce the delusion, as it would be unethical on the person if you done that.'

However, while nurses confirm that one should not deliberately agree with service users' delusions, the dilemma they face is unintentionally re-enforcing symptoms. This dilemma centres on the fact that despite their best efforts at being careful in what they said within their communicative episode, misinterpretation (because of psychosis) might still happen where the service user believes that the nurse is agreeing with his/her beliefs. Thus, while not intended, they would engage in poor practices by reinforcing delusions. Therefore, in order to protect the service user and themselves, attempts are made to hold short conversations and avoid any topic deemed as potentially risky.

Participants initially learn guardedness about being open regarding acute psychosis through a process of socialisation. This happens for service users within their own families and communities when they experience fear and/or ostracisation, being linked with dangerousness, being discriminated against and experiencing objectification, which diminishes their sense of identity as individuals. Nurses learn guardedness from colleagues through not being encouraged to talk with service users, being actively excluded from communicating with them, given advice about possible risks involved, and/or working with poor role models about how to converse with service users. Thus, they lack the competence

and/or confidence to engage with some service users. As a result, both groups have acquired guardedness before they start communicating together.

Enacting Institutional Communications

This category refers to how participants enact what is permissible in the context of existing communicative custom and practices when they start communicating with each other, within the context of mental health services. Nurses, for the most part, gain knowledge about how to communicate with service users through sharing stories about previous and current service users' interactions with each other as well as talking with them. Service users, in the main, learn it through past and present communicating with nurses.

With regards to nurses sharing stories, this occurs in a number of ways: the written word - reading service users' case notes; sharing a service user's illness history with each other; and recalling previous difficult or positive interactions with service users. In these contexts, nurses seek guidance, support and to learn from each other how to communicate with service users. This issue arose when talking to N5 about how she decides what to talk to service users about:

'Initially when someone comes in and they are acutely psychotic, you have a little history on them. You have an idea what's happening or what the diagnosis is.'

Importance is placed on reading a synopsis of a service user's psychiatric history and current care plan in their file, and/or talking to the admitting doctor, thereby, getting guidance on what to observe for and enquire about, and what to avoid prior to any contact. I wondered how much this influenced what she spoke to the service user about:

'I know that you are supposed to do your own assessment, but when you have a bit of history, you then know where they come from and what previous history they have. It would give you ideas you could work on. Say, for example auditory hallucinations. You could say something like, 'do you ever hear any voices besides your own?''

Thus, being aware of service users' psychiatric history and care plan influences nurses to ask short focused questions about specific symptoms, as these are considered indicators of the level and intensity of the psychotic experiences. It also involves noting present and past risks, such as aggression or non-compliance with treatment plans. Hence, reading case notes and/or being given information about current and previous engagement(s) with the service user, their

diagnosis, and the perspectives of others (usually fellow nurses and doctors), is seen as useful and necessary. N1 places importance on reading nursing care plans:

'Well, different things like reading care plans. When you are doing up someone's care plan, you see things like (from past care plans), monitor mood, behaviour and thoughts, develop a therapeutic relationship. Just different things like that and then when you are interacting with them, you know what to look out for, you know, what information you need to monitor how they are doing.'

Therefore, following what other nurses believe important to attend to is considered helpful in guiding the consistency of nursing care, as staff change each shift. It also provides them with a sense of validation by being able to provide useful information to colleagues. However, this practice can also have the effect of narrowing nurses' lens of enquiry, as it excludes other issues deemed not relevant.

Nurses' communications with service users also tend to be influenced by their previous behaviour towards nurses and compliance with recommended treatment. N3 noted that some nurses divide service users into two broad groups. One group is referred to as being "genuine", and do not cause many problems for nurses. The other group are generally seen as non-compliant and create difficulties for nurses. According to N3, those that are seen in a positive light are referred to in the following terms:

'Nice, polite, compliant and not aggressive.'

Nurses feel less tense and devote more time and energy towards these service users. While the other group, in particular if they also had multiple admissions, usually attract the following comments:

'It's his own fault' (that he/she has got ill again), and again some would say, 'what's the point', you know (putting in an extra effort to help him).'

'Now other staff wouldn't say that, you know, they'd like the person, but the others I think feared that, 'well, there is nothing we can do for this person', 'this is ongoing and it happens all the time', you know. Unfortunately, some nurses would agree with them.'

Hence, blame is placed on the service user for becoming ill, for not taking their prescribed medication or engaging in activities that are considered by staff to be counter-productive to their recovery, for example, drinking alcohol excessively. In these circumstances, it seems that service users are judged as wanting help from nurses, yet are seen as unwilling to help

themselves or show minimal appreciation for help given, and as a result nurses feel rejected and unappreciated. Thus, sharing stories can influence nurses in the quantity and quality of their communications with service users, thereby, becoming more guarded with a particular cohort of service users.

While some nurses learn to be guarded about communicating with service users experiencing acute psychosis for fear of causing problems accompanied by uncertainty about how to talk with them, especially in the presence of agitation or aggression, others had access to more senior nurses who modelled a more positive communicative approach. When asking N2 about where he learned how to talk with these service users, he focused on a particular approach:

'I would have learned it from being in the (name of unit) and being in the (name of ward) over the last ten-twelve years. Really it's something I'd learned from experience and from senior staff. I suppose if you are interested you'll pick it up and you'll learn as you go along; you learn how to handle people.'

In particular, he was impressed by those nurses who could calm tense or difficult situations:

'You would always know somebody who was good and they would be the ones you would relate to afterwards. You'd know the bit of jargon they'd use to get through to somebody; they would always have a bit of jargon.'

The jargon refers to how and what to say to service users in order to try to calm them if agitated or aggressive, and/or to ensure compliance with recommended treatment(s). While this approach discouraged holding prolonged conversation, it did include giving of general and specific reassurances about certain worries, and promoting the effectiveness of medication. N2 had observed more senior nurses being able to talk with these service users in a way that not only achieved the above, but eased tension within the ward environment, in particular using appropriate humour to ease difficulties:

'It would impress you and you'd kind of learn by it. You wouldn't use their jargon but you'd be using your own. You'd know how to set up the bit of rapport with somebody and establish that bit of trust and communication, which is probably important. And you always make light of... you don't make fun of anybody, but you make light of every situation and you just kind of, you know, you try and throw in a few auld jokes and things.'

Modelling these techniques not only orientated nurses to communicate with a particular intent, but with the hope that it would promote future good relationships with service users.

The ability to manage crises and ensure compliance is seen by nurses to be a permissible communication, as it is an important skill to acquire. It provides protection against possible harm and facilitates the compliance with treatment. Thus, being proficient in this practice gains validation from colleagues and provides a map of how to communicate with service users in certain situations, such as when a service user shows aggression. However, it also reinforces the view that these communications carry risks, as it is usually used in the context of unpredictable and difficult situations. Therefore, in general when communicating with service users, it was considered prudent to either become guarded or to keep one's guard raised.

Service users experiencing acute psychosis primarily learn and enact institutional talk with nurses through previous and current communications with them. One way it occurs is when past communication experiences are recalled when contemplating talking with particular nurses, which can colour their approach to current communications. SU7 recalled a past negative experience as an in-patient; she approached the nursing station to ask for medication to help her sleep:

'I was very coldly told, 'you're not written down for a sleeping tablet', felt dismissed, terrible, it was like a prison.'

'They generally made no effort to sit down to talk, and were a bit cold and distant. I'm now less likely to open up to them, as in the past I didn't trust nurses.'

This and other negative responses influenced her to enact a similar dismissive approach about talking with nurses, as she felt rejected and deemed unimportant. As a consequence, her learned wariness of nurses remained despite reporting that she currently has a good relationship with a Community Mental Health Nurse (CMHN). Therefore, service users enact nurses' approach to communication by becoming overall distrustful or dismissive of the other, yet at times can become less guarded with a particular nurse.

When SU4 learned that nurses lacked the power of discharge or prescribing/un-prescribing anti-psychotic medication it influenced his decision to be less open with them:

'I wouldn't personally go talking to nurses out of my own initiative. I feel that really they don't have a say in the matter. You know, I know they pass along ... Whether you are doing well or not, but like I really think ultimately they don't have a say in whether you get out earlier or not.'

Lack of authority can be an important factor for some service users when deciding to discuss issues with nurses, as the person that needs to be influenced is the doctor not the nurse. This was brought home to service users upon making a request of a nurse. SU2 noted that during his hospitalisation, when worried or agitated he initially approached nurses for help:

'They would often just listen to me and then say that they would get the doctor to talk to me. So, I learned that doctors are the ones you talk to about your problems or if you wanted medication or leave home. Now don't get me wrong nurses were helpful, but not to talk to.'

Hence, at times, nurses' delegation of the responsibility to doctors regarding engaging relevant service user issues, and their apparent lack of authority regarding discharge and prescribing practices, meant that some service users tended to become uninterested about being open with them. Therefore, nurses' avoidance of engaging in these issues is modelled by service users.

Another way service users enacted institutional talk was when an increase in reciprocal tension is introduced into their communications by nurses. This introduced tension often contributes to a similar reaction from service users, who in turn become on edge and begin to enact guardedness with the nurse. This generally occurs for those service users who are initially somewhat open to talk to and receive help from mental health professionals. SU1 remembered a time when her life was very stressful; her critical 'voices' had returned, and she sought help from a mental health service. Her hope was that talking about her psychotic experiences would help her cope with them. Initially she found the nurse helpful and supportive about practical problems, but difficulties arose between them when she tried to bring up her psychosis:

'I wanted to explain to her, how it (stressful events) was affecting my psychosis and how I could better develop skills to fight back. In my mind, you know what I mean?'

'But when I needed to get down to how it affected me psychologically with my schizophrenia. She would always say 'No, I can't go there I'm not trained enough, wait for the Psychologist'. She would literally put her hands out and gesture a 'stop sign'.'

She noticed that the nurse became uncomfortable and tense when the issue of her psychotic experiences was introduced into their conversations, and refused to discuss this topic:

'So over time I was getting a small bit tired of this, so I eventually left the Day Hospital, I just didn't turn up. It was better I did as I was becoming frustrated and angry with her. I thought nurses were trained to talk to someone with schizophrenia.'

Hence, when nurses show reluctance to discuss psychotic experiences despite service users' willingness to do so, some service users form the opinion that nurses are not competent in this area. As a consequence, it creates guardedness about being open with nurses, with a corresponding discouragement about getting help to manage their psychotic experiences. This introduction of reciprocal tensions was also experienced by SU3 upon his initial contact with a mental health service. At that time he believed that there was an extensive conspiracy against him. He initially met with a nurse and psychiatrist at an out-patient clinic. Based on SU1's experience of talking with a nurse, I asked about his initial impressions of conversing with them:

'I thought they were very indifferent. The nurse would say something like, 'have you any thoughts that you are being persecuted'. He said it as if like he didn't believe me. That was the worst thing. The fact they didn't even accept what I was saying was true. I knew by the way I was being asked they didn't believe me.'

'I believed it like a firm conviction. So, he was asking me in that sort of way..., he didn't seem to really care whether I did or didn't think it, he just wrote it down. They just went through the diagnostic criteria, like this, this, this, this, right, right. Okay, off you go like.'

The disappointment of their instant obvious disinterest and disbelief regarding the validity of his worries and the apparent non-engagement in conversation discouraged him to be open with them; his expectation was that they would show some willingness to discuss his concerns in more depth. Thus, when an unwillingness to engage in discussions about the psychotic experience is introduced, it has a reciprocal effect on those service users who are initially keen to discuss their psychosis in a more open way. Hence, they learn to enact guardedness with nurses.

However, other service users enacted beliefs that talking to nurses is not beneficial as medication is the answer for their difficulties. SU6 down-played the importance of discussing her psychosis with nurses. This stance was formed after talking to her psychiatrist, who told her:

'That medication was of the utmost importance.'

It was the only thing that would decrease her symptoms. Therefore, talking to nurses about her psychotic experiences that resulted in hospitalisation took a backseat. As a consequence, she kept conversations about these issues with nurses guarded:

'I didn't feel they would have an answer. The only answer lay in medication, if you know what I mean. Either the tablets were going to work or not.'

When service users adopt this position it means that while they are prepared to less guarded about practical issues, such as ward routine, or seeking general re-assurances about particular worries, a more guarded approach is adopted regarding psychosis, as it is believed that discussing issues relating to their experiences will not contribute to its resolution.

In summary, participants learn to enact institutional talk when communicating to each other in the context of a mental health service. Nurses learn what permissible communication is from colleagues and their own experience, in particular enacting existing communicative custom and practices with service users. This gives them a communicative map and sense of security about what to say and do. However, when their communications are seen as disrespectful, appear to lack the authority or competency to discuss issues that relevant to the service user, and/or anxiety is introduced they adopt a similar communicative approach to nurses. They both become guarded.

Learning guardedness describes how participants become guarded about conversing with each other, as a result of socialisation processes and enacting those communicative customs and practices that are present in mental health services. Service users' preliminary socialisation relating to becoming guarded about their experiences occurs in their community and later as a patient of a mental health service. Within their communities they learn that there is the risk of ostracisation and discrimination if they speak in an unguarded way about their psychotic experiences and/or diagnosis. Nurses' initial socialisation mainly happens within the context of working in mental health services. Here, they learn existing understandings about what is risky and useful to say and not to say, particularly about the psychotic experience. Consequently, become communicatively guarded about what to say and do when thinking about interacting with service users. This socialisation process of *learning guardedness* continues when they meet as employees and attendees of a mental health service. In this context, participants enact existing communicative customs and practices. Nurses model colleagues' style of a more guarded approach that focuses on

following established communication approaches, brief interventions and minimising risk, which can be seen as dismissive by service users. In the main, service users either maintain or develop guardedness in response to how nurses present themselves and communicate with them both historically and in the present. This learned guardedness has a protective function; to some extent it eased communicative apprehensions and shields both from possible harm or doing harm. It also provides a frame of reference regarding generally what to avoid when communicating together. However, conversely it can also create a reciprocal increase in tension, which results in both becoming guarded. Therefore, an overall level of guardedness remains with participants whenever they communicate, a guardedness that is dynamic and fluid that has the capacity to become more raised or lowered depending on what is going on between them.

How guardedness increases is explored in the next section, *experiencing risk*.

6.2.2 Experiencing Risk

This category describes the processes of how participants come to heighten their guard with each other, which occurs in the context of experiencing amplified fears that these communications could seriously decrease their sense of safety, and is likely to be unhelpful. Thus, it is advantageous that any potential risks be identified, so that understandings of permissibility can be adjusted accordingly. This ability to alter their sense of permissibility allows participants ownership of what is said and what is kept hidden. This is described in more detail by, *enacting distrustfulness* and *experiencing hostility*.

Enacting Distrustfulness

Enacting distrustfulness describes the processes of how and why participants decide to heighten their guard with each other when either one, or both, becomes distrustful of the other's motives or disbelieves the other.

Service users tend to become very suspicious of others when their inner conversations increasingly consist of worries about various conspiracies being planned against them. This issue was reflected by SU2 when he spoke about how due to a negative work environment he had gradually become very concerned that colleagues were talking about, and watching him. He brought these worries with him when admitted to a psychiatric unit:

'Well I thought the hospital (nurses and doctors) was under their operation, that all the patients were just coming in just to observe me. They were just trying to see what way I worked so they could think of the worst thing to do to me and stuff like that.'

When these kinds of worries and patterns of thinking become dominant there is also a corresponding increase in service users' sense of risk and stress levels, with growing suspicions that they are being slandered, shunned, and sometimes feeling under threat of assault. SU5 recalled worrying about being under surveillance from a government agency, which included the mental health service:

'I felt that they were keeping an eye on me and tracking where I was going by satellite. It was like 'them' and 'me' and they could see and hear me no matter what I was doing. It was terrible...'

As a consequence, she was constantly on guard about what she said and did so as not to "upset them", as she felt that they were looking for a reason to abduct her. Therefore, when experiencing these types of difficulties, the idea of talking less guardedly about these fears increases a service user's sense of vulnerability. I wondered how these worries impacted on communications with nurses. SU3 believed that hospital staff was part of a conspiracy against him. I asked how he tried to manage these concerns:

'Well, I wanted to get out of there, away from that. But couldn't straight away, so I didn't say much; just watched them.'

Hence, his strategy was to raise his guard about what he said so as to avoid being harmed. This watchfulness and hyper-vigilance about what is happening around service users generally includes what nurses are doing and saying, in that, in these circumstances nurses' body language and conversations are interpreted within a framework of possible risk and distrust. Thus, it seemed prudent to consider current interactions with nurses as problematic, and where raising one's guard is necessary.

Another issue that influenced service users' communication with nurses is when they experience hearing voices, which often introduces a raised guardedness. In the main, these voices include known and unknown people and occur internally and in the external space around them. When asked, SU6 said that her voices encouraged her to be guarded about what she said to nurses:

'Now the voices were really bad at that time and they were telling me not to tell the nurses anything because they were working with the devil, and if they knew what I was doing to try and keep the devil at bay, they would stop me doing it and I'd be at his mercy then.'

In her attempts to protect herself from the devil she did not take her medication, as the voices told her that nurses were working for the devil, because they encouraged her to take medications. Hence, some service users' experiencing voices are often at odds with nurses' views, resulting in distrusting their advice due to a belief that it would place them in an exceedingly vulnerable position. So, those service users who hear voices can become distrustful of nurses due to worries generated by these voices and raise their communicative guard to provide themselves with some protection. In addition, they also struggle when conversing with others, as they are simultaneously interacting with their voices, and this is often noticed by nurses.

Another factor that increased service users' vigilance and distrust of nurses is being uncertain of what their motives are when communicating together. SU7 recalled a time when she was talking to a Community Mental Health Nurse. The nurse wondered aloud was she becoming unwell again, as she had voiced concerns about some people were "out to get her". At that point SU7 raised her guarded about what she said; she feared that the nurse might recommend hospitalization:

'I worried that I was about to be admitted involuntarily to hospital, and thought that 'they are coming to get you'. Later I got the train to Dublin to avoid hospitalization but got really bad, and was really worried people generally were out to get me. I felt something in my brain getting tighter; I thought people were trying to turn a screw in my brain.'

At that time, her worry was so great that she left her home in order to avoid hospitalisation. Thus, for service users, being distrustful allows them to quickly identify possible risks to them, which involves being vigilant about what nurses are doing and saying. Therefore, recognizing these perceived risks facilitates the ability to change understandings of what is permissible, in order to try and stay safe. This distrust is sometimes created without the nurse being initially aware of it but it can also come to the fore when in conversation. However, distrustfulness relating to the psychotic experience can be amplified by what occurs between them, which results in distance being created between both at a time when service users are generally feeling burdened and distressed.

Nurses also hold suspicions and distrust regarding service users' experiencing acute psychosis. This suspicion and distrust mainly relates to their judgements regarding the capacity of service users to engage in reasoned conversations due to the apparent presence of such experiences as delusions, hallucinations and distorted thinking. In particular, this occurs when a nurse believes that a service user has a significantly decreased ability to engage in meaningful conversations, as he/she is too ill, and as a consequence they do not have ownership over their own thought and behaviour. By adopting this stance it helps nurses with the identification of possible risks to the safety of their communications, and with finding ways to manage them. N4 understood someone experiencing acute psychosis as:

'Somebody who is out of touch with reality and there is no rhyme or reason to anything they say.'

In other words, due to a mental illness, it is believed that generally these service users are beyond engaging in rational conversations as their thoughts and beliefs are not based in reality. Hence, nurses are suspicious of the validity of what they say. N7 concurred:

'They are very sick, you know, confused in their thoughts, seeing and hearing things that aren't there. They have lost control of themselves.'

This diminished trust in the ability of service users who are experiencing acute psychosis to have control over their own thoughts, and hold reasoned and rational conversations, is based on their belief that they are interacting with someone whose mind is ill, and so is unreachable and at times incomprehensible. Hence, according to N3, these service users have decreased capacity to make the "right" decisions because:

'Their mind plays tricks on them.'

This judged reduced ability to make rational decisions refers to being seen to have reduced capacity to engage in an internal process that considers various courses of action among several alternative situations, then making a choice. As a consequence, nurses believe, at times, that service users make incorrect decisions regarding their care and life in general. Therefore, it is deemed necessary to make decisions on their behalf. N2 rationalised this approach succinctly when stating:

'It is for their own good and benefit.'

Therefore, nurses assume authority to make some decisions for the service user, for example ensuring medication compliance, making recommendations about hospitalisation, deciding to place their experiences into the realm of illness, or choosing to restrain a service user when showing aggression. N4 outlined the process of making decision on behalf of a service user:

'Listen while some of these decisions are made with the doctor, but there other times when you need to come to your own decisions even if the person doesn't agree, like, recommending hospitalization or increasing medication'.

This assumption of authority is considered necessary in order to facilitate the treatment of the psychotic experiences, in particular for those who refused to cooperate. However, it also creates distance between nurses and service users as it promotes a parental/disempowering approach, from the nurse towards the service user. Though, it also provides nurses with a rationale to make these decisions and to engage in practices that they believe are ultimately helpful for the service user.

Service users experiencing acute psychosis are aware of being disbelieved with an accompanying sense of disempowerment; to varying degrees. SU8 realised this while hospitalised. At that time, he worried that his life was being portrayed on a popular television soap opera without his permission. When these worries became too burdensome, he sought out nurses to talk to. He paraphrased some of their responses:

'Listen, you are sick and these thoughts and worries are not real, but will go away when you get better.'

At that time, he felt that these re-assurances, while attempting to give him hope that at some future point his fears would dissolve, did not help him in the present. Therefore, neither party believed the other; nurses did not believe SU8's story held any validity, as it was just part of an illness process, while he believed that his worries were valid, hence, dismissed the nurses' perspectives. As a result, this dis-believability created communicative distance and raised guardedness between them, as both strongly believed their viewpoints were valid.

In summary, participants raise their guard when distrust is created between them, due to suspecting the other's motives or disbelieving the validity of the other's opinions and as result are keen to identify any possible risks that could leave them and maybe others in a vulnerable position. Therefore, enacting distrustfulness facilitates them to raise their guard and change their understandings of what is permissible to say. However, conversely it also

has the potential to recursively keep their guardedness raised, as from this position, nurses' and service users' opinions/views have minimal validity or relevance for the other, so distrust is maintained unless one/both changes their position.

Experiencing hostility

When participants encounter hostility or the threat of same, their guardedness about communicating together is heightened. This occurs when communications are experienced as unpredictable and potentially dangerous.

Nurses frequently mentioned that was it difficult to predict what would happen when talking with service users with acute psychosis, as they believe that there is a propensity for hostility and aggression, especially in an in-patient facility. N3 maintained that:

'You just don't know what's going to happen. The patient is usually very agitated and maybe threatening and not responding to any reassurances. Sometimes they need to be secluded and medicated, but it's worrying, you know, they are ill and upset and could resist. I've seen nurses getting hurt...'

However, for nurses, due to this perception that service users are unpredictable and have the potential to become aggressive, their communications together are associated with feelings of tension, worry and uncertainty. N2 also highlighted this issue, in particular when it occurs during an admission process. He spoke about his impressions of these service users upon admission, and in the early stages of their hospitalisation:

'Somebody who maybe is quite hostile and aggressive on admission and that may not want or feel they need to have treatment within a hospital setting, and there might be a lot of hostility towards us as nurses.'

On these occasions, due to past experiences, he considers it necessary to prepare in advance for possible aggression. Therefore, in order to protect himself and others, he follows established hospital protocols. One of these protocols is:

'Having teams of nurses ready in case of trouble.'

Depending on the judged level of risk these teams are either present with the admitting nurse or in close proximity, and will intervene if hostility is shown. If a service user becomes aggressive, it is deemed necessary to employ what are known as:

'Control and restraint techniques.'

N2 understood this as meaning that nurses would restrain the service user and place him/her into a seclusion room where he/she would be put in isolation from other patients in a specially designed room for a defined period of time. He believes that it is the safe and prudent thing to do, as it reduces the physical risk to nurses, other patients and ultimately the person with psychosis. Therefore, when deemed necessary, following established protocols provides nurses with a guide for how to act when they judge that a situation has become dangerous.

However, despite the intention to use seclusion as an emergency protective intervention, some service users have a different perspective. SU9 spoke about being secluded on a number of occasions, which he experienced as traumatic:

'It was years ago and I still remember it like it was yesterday. The first time was very traumatic... I'd never been in a psychiatric hospital before, I refused medication and I was held down and injected by six staff. What I feel really strongly about is that no one gave me a choice... they might have said to me you need medication, but no one said if you don't take the medication we will have to force you to have an injection.'

He felt that these nurses were unfairly aggressive towards him, and that he should have been given an opportunity to discuss treatment options and rationales behind this decision. There was also resentment and felt disempowerment that others made decisions and enforced them on his behalf without consultation. These circumstances lead to nurses being viewed negatively and communicating with them as unpredictable and potentially dangerous. Hence, service users raise their guard about what they say and do in order try to reduce these perceived risks. Yet, nurses consider seclusion as sometimes necessary, not only as a protective measure, but occasionally to facilitate the administration of anti-psychotic medication (if the service user experiencing psychosis consistently refused same); it is believed that it greatly contributes to a service user's recovery. On the whole, both consider that communicating in the context of hostility and aggression is unpredictable and risky, and that one's guardedness needs to be raised. However, while on one hand raising guardedness is seen as necessary, on the other hand it results in a decreased ability to understand the other's perspective; hence, it contributes to a shared perspective of increasing sense of risk and unpredictability when communicating together.

However, some service users' revealed that on occasion they were aggressive towards nurses. When asked, SU4 revealed that he had been verbally and physically aggressive towards nurses. He described his behaviour occurring in the context of wanting to leave hospital without permission:

'I was kind of aggressive and....very afraid, because I would have a....notion that I didn't need hospitalization. I didn't like being confined and told what to do. I felt alone and afraid.'

He was very unhappy about being hospitalised against his will, and tried to leave by kicking open doors, resulting in physical confrontations with nurses. By and large, while these service users expressed regret, they explained their aggression as a reaction to feeling very afraid that something bad was about to happen, and/or been locked up without their permission and wanting to leave.

In summary, nurses tried to prepare for and to offset potential unpredictable and dangerous communications and interactions by trying to ensure the safety of service users and staff by adhering to accepted ward and service protocols. However, these practices impact negatively on their relationship with service users, which a resultant amplification of both parties' guardedness and tension when communicating together. Also, within the context of *experiencing hostility*, attempts are made by service users to guard themselves from feeling disempowered regarding not being able to make decisions that are congruent with what they consider right for them. It is seen as an aggressive attack on their sense of personal integrity and sense of identity.

Some service users fear that less guarded communications with nurses risk decreasing their personal agency. SU8 had experience of this through forced hospitalisation and medication after his behaviour had caused a lot of worry within his family, and was not complying with prescribed treatments. At that time, he disagreed with doctors' and nurses' views that he had a mental illness called psychosis. I wondered why he did not agree:

'I didn't really buy into it. It didn't fit for me, I felt what I was experiencing was a type of religious thing. I was connected to the divine.'

As a consequence, he refused to engage in offered treatment. However, his fear of losing personal agency was especially heightened when hospitalised, where it is considered of the utmost importance for those with acute psychosis recovery that they take antipsychotic

medication, and remain hospitalised until judged well enough to leave. This led SU8 to come into conflict with nurses, whose role included ensuring medication compliance:

'They [nurses] were coercive in this sense, 'you can take it [medication] in syrup, you can take it as a pill or you can take it in an injection, and if you don't take it in the syrup we'll inject you anyway and put you in a padded cell'. So that's like... rock bottom.'

'Like compliance is a very big thing. If you start being non-compliant you end up staying longer, or you end up being in the seclusion room more and being injected against your will.'

He felt that despite his objections and deep upset there was no choice but to eventually comply. In these types of circumstances service users feel coerced into complying with the implementation of treatments prescribed by doctors and implemented by nurses, which for them means either ultimately acceding or being forced to. It symbolises for these service users the loss of their personal agency and sense of who they are. This is also brought home when requesting something from nurses, such as information, their own clothes or when queuing for medication. It results in feelings of resentment and raised guardedness so as to try and gain some personal control in a place where they felt that they have none. SU5 remarked on this position of experiencing an increased sense of powerlessness:

'Sometimes, if you are not a courteous person then you'd be written down as 'un-compliant'. You know, the nurses have that leverage to use against patients where they can say, 'well, the patient is being abusive to staff' or something'. They can write something like that down. You know, and they can complain to the doctors and the doctors might change the medication or something like that.'

Hence, recognising that nurses have power to influence the length of hospitalisation and/or being prescribed extra medication is important, as it allows service users to begin to strategise how to try and retain or regain some personal agency. One way this is achieved is to explicitly adhere to offered treatment and ward rules as it not only avoids negative consequences, but it gains privileges. SU5 advocated taking this approach:

'It's an incentivised system. If you are compliant, so you can get back onto the ward from seclusion, and maybe then go onto the sub-acute ward. You know, there's more freedom on the sub-acute ward.'

Therefore, while superficially it appears that some service users are compliant, they hide disbeliefs about medication and the need for hospitalisation by not revealing them to nurses. In this way, they are able to retain a sense of personal power by implicitly holding on to their

own decision-making process. In other words, a way is found to resist what they consider an atmosphere of control and coercion. In addition, they also try to guard themselves against loss of personal agency by recognising who carries the decision making-authority, and either reject this authority or explicitly comply while implicitly holding other views.

In summary, *experiencing hostility* describes how participants (mainly in in-patient settings), identify and experience increasing risks to their physical and psychological safety and personal agency. When this occurs nurses adhere to certain safeguards to minimise or avoid these risks, by trying to ensure the safety of service users and staff by raising their communicative guard and by adhering to accepted ward and service protocols. However, these practices often impacted negatively on their relationship with service users who in turn raise their guard with nurses. In particular, raising their guard occurs when they experience disempowerment due the process of hospitalisation and ward protocols and practices, and when they try to explicitly and implicitly resist offered treatments. Hence, both parties feel it is necessary and prudent to raise their guardedness so as to protect themselves and others; however it can also contribute to recursively keeping guardedness raised.

Experiencing Risk describes how nurses and service users experiencing acute psychosis raise their guard about communicating together when certain risks to their or others' safety are identified and/or experienced. The identification of these risks creates a concurrent change in understanding of what constitutes permissible communications, thereby, it not only makes their conversations somewhat safer; it allows ownership over what is said. One way that nurses and service users recognise possible threats to themselves or others is by being distrustful of the validity of the other's opinions or motives, which allows the instigation of certain safeguards. These safeguards include being vigilant about what was happening in their environment and what they are told, and developing both a physical and psychological distance between each other. Another way is to identify what constitutes increasing risks to one's physical and psychological safety, and personal agency. When identified, attempts are made to minimise or avoid these risks by making them more predictable, such as, following established protocols and practices, or becoming aware of power differentials and feigning compliance. On the whole, raising one's guard provides safeguards and protection, as it gives some sense of safety when it is judged that communications have become very risky and dangerous. However, it also can intensify a sense of distrust and distance between them.

As already indicated, despite a sense of increased risk and tension, nurses and service users' continue to communicate with each other, by generally *keeping conversations light*.

6.2.3 Keeping Conversations Light

This category refers to how participants manage to communicate together within in context of raising their communicative guard. They endeavour to do this by keeping their communications 'light', through avoiding prolonged or difficult conversations, asking/answering questions in a way that generates short responses and/or strategizing what is advantageous to say and do. This occurs by using and accepting general reassurances about various worries, concerns and hopes, as well as service users minimising or concealing their psychotic experiences, while nurses through conversations and observation attempt to identify and reveal what they consider are signs and symptoms of psychosis. This section is describes in more detail by, *using reassurance* and *playing the game*.

Using Re-assurance

This refers to how participants attempt to resolve the dilemma of trying to stay safe, by just saying enough to each other, so that the service user feels somewhat reassured regarding any worries and distress he/she is experiencing, and the nurse is able to provide some help for distress/worry, while at the same time both avoid causing or experiencing any problems. Reassurance is a term frequently used by nurses to describe a particular type of communication with patients. Its intent is to reduce anxiety, distress, agitation and sometimes aggression. While service users often seek to be reassured within these joint communications, both continue to attend to the other to assess what level of *raising guardedness* is appropriate.

Nurses and service users manage their predicaments about communicating with each other by just saying enough. These predicaments come to the fore for nurses when approaching a service user who is showing distress. N7 explained how she attempted to achieve this:

'The person needs to feel that they are being looked after and they need to know that they have somebody who is prepared to listen to them. You know, prepared to make that human contact. You just can't leave them alone, but you should not make things worse. What you do is to make your conversations, light enough, you know. It doesn't always have to be heavy.'

Her concern encompasses connecting in a way that is useful for the service user, in particular, by showing interest in their worries and them as a person. The dilemma is to achieve the above while not creating problems. Hence, keeping conversations on the light side by

offering brief specific reassurances and talking in a general way about issues pertaining to the service users upset is considered helpful. This approach aids attempts to avoid delving into what she referred to as “heavy” topics, which usually includes in-depth discussions about service users’ fears and concerns. N6 agreed with this approach and recalled a distressed service user who believed that there was a demon standing beside her hospital bed:

‘You don’t agree with them that this is happening [delusion or hallucination], but you’d say, I’m not experiencing it’. You try and alleviate their anxieties and worries about it, by hoping that you can empathise with them and they can... talk about it a little without feeling you’re re-enforcing their delusions.’

She tried to respectfully and calmly reassure the service user by telling her that she could not see the demon, and passed her hand through the space the service user was pointing to. In this way, N6 attempted to ease the person’s worries by giving enough reassurance so as to reduce their distress, while not discounting their experiences completely or making things worse. The intent is not only to ease the service user’s upset and distress, but also to have a reciprocal effect of easing the nurse’s worries about causing any harm. In other words, the service user’s response also unintentionally reassured the nurse. N4 also thought it important that at these times nurses should stress the importance of promoting a sense of security:

‘I suppose reassure them that where they are at the moment is a very safe place. I don’t think that I’d discredit what they are saying, but I’d just keep coming back to the safe place where they are, and how they were going to be looked after while they were in there.’

This message is frequently repeated in response to service users’ various fears and worries, until they seem calmer and less concerned. The rationale for this approach is that the service user is seen as mentally unwell; he/she has a “confused mind”. Therefore, giving basic regular reassurances that emphasise the protective nature of hospitalisation and nurses’ benign intentions, is something they could understand and find reassuring. It is also hoped that repeating these reassurances would deflect service users from attempting to engage in communications that nurses considered too risky.

A number of service users reported valuing receiving reassurances from nurses. As previously mentioned, SU7 was not interested in talking to nurses about her symptoms, as she believed that medication was the only thing that would help; however, she also placed importance on communications with nurses about other issues. I wondered how it benefited her:

'Just I suppose emotional support, you know that somebody cared. Because as you know it's a very alienating experience when you are in hospital and I was there a long time.'

So, despite her rejection of talking with nurses about her psychotic experiences she still valued interacting with those who showed that they cared about her and was interested in her as a person; it made an important difference. These daily interactions reassured her that she was not alone in her struggles; hence, she felt more at ease:

'I think people wouldn't recover without the nurses in a way. They are still a very human presence of the staff really, and they are... they did show themselves as caring.'

This human presence and associated reassurances is recognised as an important part of easing service users' worries and distress. SU6 agreed with just receiving general reassurances and guarding her symptoms from nurses, because of the frequent changes of nurses when an inpatient:

'Different nurses were coming and going all the time. They come over and you're starting your story again and it's too long to tell anyway, you know. So I'd kind of say, 'I'm fine or whatever'. I'd talk to the doctors, they don't change.'

However, despite her frustration at the inconsistency of nursing staff she valued the day to day contact with nurses, and accepted and felt benefit from general advice regarding sleep and promises of recovery. However, the problem of lack of consistent nurses impacted on her interest and ability to build a relationship with a particular ward nurse, as she was keen to discuss her problems.

In general, offering and receiving reassurances through just saying enough and avoiding or causing difficulties facilitates nurses and service users to be able to temporally ease worries and upset, within the context of their guard being raised, in particular those nurses who appeared sincere in the reassurances and could connect to service users on a human level.

Another intent that nurses have when using reassurance is to play for time. Its purpose is to delay or put off less guarded conversations until they judge that medication has begun to ameliorate the psychosis, and/or feel safe enough to be less guarded. N3 considers the approach of giving re-assurance as helpful since it temporarily reduces service users' upsets and worries until medication begins to reduce the psychotic experiences:

'I do think the first port of call would be to medicate somebody. So as to take the edge off that acute phase and when... when they calm down, and they've got used to the environment am... then you can start working on conversations and trust or whatever else. But at the very initial stages medication would be the only treatment there.'

'Really you are just trying to contain it until the medication starts to work, and all you are doing is trying to keep the person calm and avoid any major incident until then.'

The view that medication is the most important ingredient for the resolution of psychosis is held by most nurses, hence, discussing and exploring a service user's worries during its acute phase is not necessary and carries those risks previously discussed. N2 also believes that when acutely unwell, trying to hold a conversation with service users about their difficulties is not beneficial:

'You can't converse with them... if they are that unwell, anything you say is not going to make a blind bit of difference.'

I wonder what he would do if a service user approached him and wanted to talk:

'I usually let them ventilate. You know what I mean, we'd let them talk about it.'

Letting service users' ventilate means that they do most of the talking while nurses listened, at the same time portraying interest through verbal and non-verbal encouragement. The hope is that the person feels listened to and somewhat reassured. However, if N2 thought that this approach was not working, and the service user persisted in trying to engage him about their psychotic experience, he would recommend a doctor should answer these questions, thereby avoiding less guarded communications. However, this has the potential to indicate to service users that some nurses are unwilling or not competent to talk about their psychotic experiences. Some service users become frustrated when they just receive general reassurances from nurses with an accompanying avoidance about addressing their issues of concern. This approach is interpreted by service users as nurses being more interested in offering, talking about, and ensuring medication compliance and ward routine rather than talking about their issues. This was noted by SU4:

'They [nurses] were only interested in assessing the effectiveness of medication and treating me as an illness.'

'It's like rather than opening your mouth to talk, it was open your mouth to take a tablet.'

He believed that nurses mainly wanted to give him medication, and enquire about its effectiveness rather engaging in those issues that worried him. Therefore, for him, when experiencing acute psychosis most nurses consider taking medication and offering general reassurances is a lot more useful than talking. In these circumstances, it is felt that nurses are not really interested in them as a people, hence got little value from general reassurances. SU1 had a similar perspective on the offering of general assurances and medication. This was not only brought home to her when a nurse she was attending in a Day Hospital refused to discuss her symptoms (see *learning guardedness*), but also when a psychiatrist said:

'If you don't take your medication there is nothing more we can do for you.'

I wondered how she understood this:

'Well, it's like medication is the only thing that important. Talking about things is not important, but I wasn't going down that road.'

She decided at that point to continue rejecting medication, mainly due to past experience of severe side-effects and a desire to discuss ways to manage her voices. With regards to nurses views on medication, it is generally considered as part the process of giving reassurances, as there is a belief that anti-psychotic medication is the main treatment that will either resolve or at least manage acute psychosis. Hence, putting off less guarded conversations avoids or minimises potential difficulties, but it influences some service users to become disillusioned about the help being offered by nurses and the service as a whole.

In summary, using reassurance allowed participants to use and accept (and sometimes value) reassurances when giving and receiving help for worries and their associated emotional upset without having to delve too deeply into what are considered risky issues. It helps to temporally ease service users' worries and distress. One way this is dealt with is by just saying enough to ease worries and concerns without service users feeling dismissed or his/her experiences being completely discounted. Another way is to communicate with the intention of playing for time, such as delaying less guarded discussion of topics until it was judged that medication had begun to resolve the psychosis. This made communications safer. However, it is likely not to be so helpful if the service user wants to talk in more depth, does not feel the nurse is interested in him or her as a person, or is only offered medication.

Playing the Game

This refers to another approach that participants engage in to try and keep their conversations light, where both play the game of attempting to reveal and conceal psychotic experiences. The game usually begins when a nurse asks a service user about the level and intensity of his/her psychotic experiences, and in response some service users' decide to try and keep those experiences hidden, prompting nurses to try and discover them. Nurses consider that establishing the level and intensity of a service user's psychotic experiences is important, as it provides indicators of improvements or dis-improvements in a service user's psychosis. However, service users often try to guard against revealing their psychotic experiences to nurses, so as not to be placed in a more vulnerable position and/or to gain an advantage. Hence, they try to conceal their symptoms.

At some point in their communications with nurses, service users realise that nurses are keen to know the content of their thoughts and become aware that their behaviour is being observed, in order for nurses to judge their level of wellness or un-wellness. SU4 became conscious of this practice early in his interactions with nurses:

'I realised that they are just trying to assess my mental state. You become aware of that...'

I wondered how he knew nurses were trying to assess him:

'I guess for example, they'd ask 'how are you?' would never mean 'how are you?' It would mean like 'are you crazy?' They would also ask things like 'are you hearing voices?'.'

'They'd be asking me questions that were very probing. It feels like you're being interrogated...'

SU4 was not content with this approach as from his perspective it occurred in the absence of a genuine interest in him and how he was faring with his difficulties, and where the questions were specific, closed and not within the context of the flow of general conversations. When service users discover that quite often the main intent of nurses when conversing together is to assess their level and intensity of psychosis. They realise the value that is placed on this information, as it influences nurses and other mental health professionals in their decision making regarding the service user's treatment. As a consequence, some service users' strategise what to say in these encounters. SU6 discovered that giving certain answers was advantageous for her:

'You want to give the right answers. You know, because ultimately you want to get out of the place. So, you are saying whatever you think is the right answer.'

The right answers included either minimising or denying the presence of psychotic symptoms so as to gain privileges, such as leave home. It is also used to avoid negative consequences, for example, prolonging her hospitalisation. SU9 recalled a fellow patient telling him how to influence his treatment regime, with the advice:

'Act crazy in the early days and then be cute after that, and then keep everything to yourself. Be polite and don't say anything. That way it looks like you gotten better.'

The intent was to initially appear overtly unwell then conceal those signs and symptoms that are associated with psychosis from nurses, as well as being compliant, thereby appearing improved. He referred to this strategy as:

'Playing the game.'

This game from SU9's perspective involves carefully choosing what he revealed about his inner conversations, and like SU6 giving what he thought were the 'right' answers to nurses. In other words, when conversing with nurses there were occasions when it was considered beneficial to pretend that his/her psychotic experiences had diminished or were absent. This understanding of what is useful or risky to reveal to nurses, means that some service users engage in a game of trying to feign wellness, judging that at that moment it is more advantageous to raise their guard about their experiences, and pretend that their mental health has improved.

Concurrently, nurses are keen to discover the level and intensity of service users' psychotic symptoms, either by asking direct specific questions and/or through observation. As already mentioned, nurses consider that it is useful and helpful for service users' recovery that current levels of these symptoms be ascertained. In addition, they are aware that service users try and hide their symptom so as to get a reduction in medication, and either be discharged from hospital or avoid hospitalisation.

N4 believed that this was a common occurrence and conceptualised service users' intent as:

'Trying to mask their symptoms.'

He understood masking symptoms as service users' conscious attempt to hide their illness related worries and behaviour from nurses, by trying to present as well. They try to mask their psychotic experiences. I wondered how he would know if this was happening:

'You might sit down with someone and say, 'well how are the voices? Are you still hearing them? Are they still telling you to do this, that and the other thing?' They might say, 'Oh no, they are not there anymore'. But when you actually observe them from a distance you will either see them smiling inappropriately to themselves, they will be looking up at nothing or they will be saying something just under their breath.'

He noted the apparent difference in what they said and how they behaved, hence, doubted their honesty. Nurses also noted when service users suddenly began to deny experiencing any symptoms, but their behaviour seemed to indicate that they continue to experience them. This usually resulted in an increase in observation for any signs of psychosis, such as talking or laughing to oneself, or behaving as if they are under threat – avoiding interacting with others. In the main, nurses were quietly confident that the symptoms would eventually be revealed. N6 agreed:

'When a delusion is there, a person cannot mask it too well simply because they have to interact with that delusion.'

This approach for N6 indicates that when a service user is interacting with a delusion it means behaving as if the delusion was true, for example, a service user who believes that someone is trying to poison them might only eat food brought in by friends. Apart from increased observations, nurses use two other practices in order to try and reveal the psychotic symptoms. N2 felt that in these circumstances and in the absence of obvious aggression, it was permissible to ask more short direct questions:

'You can challenge them in a soft way by saying, 'look, I observed you smiling inappropriately, I observed you talking out the window, to something. So I still feel that it's there'.'

The intent is to prompt the service user to reveal their psychotic experiences that he/she is trying to conceal. The second practice is to share this information with his peers:

'I'd tell other staff as well so they can watch out for it.'

Upon receiving this information, his colleagues would usually devote time to concentrate on trying to spot the service user's psychosis, through observing and checking for indicators of

illness. However, for some service users, this intensification of observation encouraged them to become even more guarded about their experiences, by intensifying efforts to conceal symptoms and distance themselves from nurses, so as not to put themselves at a disadvantage.

In summary, *playing the game* describes a dynamic and fluid process that occurs when service user participants attempt to conceal their psychotic symptoms and where nurses try to reveal them. Some service users believe that it is advantageous to conceal their symptoms and minimise any behaviour that nurses associate with the presence of psychosis in order to gain an advantage or avoid putting themselves in a vulnerable position. Upon noticing or suspecting that a service user is feigning wellness, nurses tend to increase observations, share this information with colleagues and sometimes genially challenge them in order to uncover the psychotic experiences. Hence, they engage in a reciprocal withdrawal – pursuit interaction, where they both strategize about what to say and do, in order to hide or reveal the psychosis experiences, thereby keeping their conversations on the light side.

Keeping conversations light is the process of how service users experiencing acute psychoses and nurses manage to communicate together in the context of keeping their guardedness raised. This is achieved when they use and accept general reassurances when giving and receiving help for worries and its associated emotional upset without having to delve too deeply into issues. In particular, by just saying enough to ease worries and concerns without service users' experiences being completely discounted. In addition, they also endeavoured to play for time, by putting off more open conversations until it is judged that medication had begun to resolve the psychosis, or trying to preserve one's personal agency by complying with recommended hospital treatment until discharged. Another interactional pattern both engage in is playing a game of trying to conceal and reveal the psychotic experiences. Some service users feigned wellness, so as to try to reduce risk and to gain privileges. Concurrently, nurses engaged in a process of trying to unmask a service user's symptoms, while at the same time keeping communications specific and brief. Therefore, keeping communications on the light side enables both to converse in a way that feels somewhat safer, at times offers a way to give and accept help for worries and distress, but means that communication remains within the context associated with *raising guardedness* and its associated distrust.

6.3 Summary

This chapter described a sub-core category of *guardedness in communications, raising guardedness*, in which participants, formed, integrated, and enacted understandings of what they considered risky communications with each other, thereby were able to establish what was permissible to say at any moment in time. Their initial guardedness occurred through a process of learned socialised wariness regarding talking unguardedly about acute psychotic experiences. This learned guardedness about what was permissible to say and do has a protective function; to some extent it eases communicative apprehensions and shields them from possible harm. However, it also introduces a reciprocal interactional tension that results in both parties becoming more on guard when conversing. It is an overall guardedness which remained whenever they interacted, which had the capacity to become more raised or lowered as needed. Guardedness becomes more raised in the context of an increasing sense of communicative risk. It occurs when fears are amplified that these communications would not only seriously decrease their sense of safety, but at times be quite unhelpful. Perceived risks identified and/or experienced included suspiciousness of the validity of the other's opinions or motives, and possible risks to one's physical safety and personal agency. Thus, it is advantageous that any potential risks be quickly identified, so that understandings of permissibility are altered so one's guardedness can be raised. This flexibility allowed nurses and service users' varying degrees of ownership of what was said and what was kept hidden. However, it also intensified a sense of distrust and distance between them. Despite these fears and concerns, communication continues between them, by keeping their conversations light. This is achieved through making risks more predictable, such as, following established protocols and practices, or becoming aware of power differentials and feigning compliance, in addition to the use and acceptance of reassurances when giving and receiving help for worries and their associated emotional upset, without having to delve too deeply into issues, in particular, by just saying enough to ease worries and concerns without service users' experiences being completely discounted. Another way to keep conversations light was to communicate with the intention of playing for time, such as, delaying less guarded discussion of topics until it was judged that medication had begun to resolve the psychosis, or to try and preserve one's personal agency by complying with recommended hospital treatment until discharged, or by masking symptoms and by feigning wellness. Therefore, keeping communications on the light side enabled both to converse and interact within the permissibility associated with *raising guardedness*.

However, on occasion, some nurses and service users experiencing acute psychosis want to communicate with each other in a less guarded way, as they judge that at that moment in time it is a more appropriate/helpful way to give and receive help so as to reduce unease or to just connect as human beings. As a consequence, they tentatively engage in a process where guardedness is lowered between them.

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Chapter 7. Lowering Guardedness

7.1 Introduction

This chapter describes in detail *lowering guardedness* the second sub-core category of *Guardedness in Communications*. The chapter explores some of the reasons why nurses and service users deem it is useful and timely to lower their guard when communicating together, and how they converse within the context of attendees and employees of an Irish Mental Health Care Service.

7.2 Lowering Guardedness

Lowering guardedness refers to why and how participants become less guarded when conversing with each other in order to discuss relevant issues in more depth. It means taking risks to engage in a more open and deep communicative relationship so as to give and receive help. This entails developing a mutual sense of safety and trust that allows both services users and nurses to engage in conversations about issues of importance and concern to both parties.

This occurs when participants begin to develop safety and trust between them where explicit and implicit permission to talk is given and received, where either are prepared, or come to be, less guarded with each other in the presence of certain indicators. These indicators include: lack of hostility or distance; willingness to converse; showing respect; and treating concerns in a serious manner. Generally, when guardedness is tentatively lowered, it is initially considered temporary, but sometimes it can become more sustained. However, these less guarded communications only become sustained if sufficient sense of safety and trust is developed between them. When less guarded communication occurs, issues of concern get addressed in a way those involved find useful and helpful, and it helps nurses and service users to feel more at ease about communicating together, thereby promoting a more shared approach when trying to ease identified burdens. However, if either one finds that the risk to benefit ratio changes, they can raise their guard in order to protect themselves and others, thereby establishing a different boundary to their communications.

The process of events of *lowering guardedness* generally does not happen strictly sequentially, and incorporates the sub processes *developing safety and trust*, and *conversing about issues of concern*.

See figure 7 below as a diagrammatic representation of the sub-core category *lowering guardedness*.

Figure 7.

Lowering Guardedness				
Developing Safety and Trust			Conversing about Issues of Importance and Concern	
Making Connections	Observing and Timing – Choosing a Safe Place	Trusting the Other	Creating Joint Understandings	Easing Worries

7.2.1 Developing Safety and Trust

This category refers to why and how participants began to develop a sense of communicative safety and trust between them so as to develop less guarded communications. The creation of safe and trusting communications is central to lowering their guard. This process develops in the context of showing a willingness to spend time with each other, in conjunction with making and keeping promises. When nurses and service users engage in the above, it promotes trust, as it engenders a sense of dependability and interest, which in turn produces positive anticipation towards any future conversations. It is described in more detail by *making connections*, *observing and timing – choosing a safe place*, and *trusting the other*.

Making Connections

This refers to how participants begin to create the communicative permissibility where less guarded communications are possible. It usually commences within the context of giving and receiving those general reassurances linked with *raising guardedness*, with an accompanying internal debate within the service user or nurse between becoming less guarded and the potential risks involved. Decisions to lower one's guard are influenced by either being able to connect to the other person's life story or problems, and/or becoming curious about the illness/psychotic experience narrative.

One way nurses and service users connect to each other is when they attempt to understand the other's perspective, even when interactions are tense and difficult. N2 raised this issue when talking about service users who were showing hostility and aggression, and possible reasons behind their behaviour:

'They might not want or feel they need to have treatment within a hospital setting and they might not be agreeable to any offered treatment. They're usually in turmoil and might be frightened of others.'

I wondered what these service users might be frightened of:

'Well there are certain things, especially if the person was really experiencing hallucinations. Like they were seeing things that you couldn't see or they were hearing or smelling things that you weren't hearing or experiencing. This can be really frightening for them and they might respond in an aggressive manner.'

He was attempting to imagine what it was like for the service user to have these frightening experiences, and also understood that they would feel threatened and were likely to respond aggressively if they had:

'Six or seven people [nurses] standing over them in a hostile manner, and maybe he is wondering 'are these lads just going to pull the clothes off me?'

In other words, N2 understood that when service users had upsetting internal experiences, in addition to feeling under threat, and/or believing that they had no control over what was happening, it could add to or provoke hostility and aggression. On these occasions, N3 tried to connect to these service users by creating a communicative space, not only to deescalate the risk of violence, but to make a connection that would allow them to begin to talk and hear each other. He remembered one man that was brought into hospital involuntarily by the police, and who was acting very aggressively and wearing handcuffs:

'I explained to him that the reason he was admitted was, 'that everybody; doctors, the guards and their family were worried about him and they think that he is unwell, but I am here to try and help him'. You would sit down and say, 'I'm here to help you through your bad times', and 'anything you need I'll try my best to help you'. You approach it softly.'

He attempted to make a connection by lowering his guard to establish with the service user that he was not a threat. This was achieved by removing himself somewhat from the decision of others regarding hospitalisation, reminding the service user that there was a lot of worry

about him in his social sphere, but he was there to be of help. Hence, attempting to understand service user experiences and perspectives contributed to developing connections.

SU5 recalled a time when she was really worried and upset that she had been verbally abusive to her mother as a teenager, and somehow contributed to her death (even though she was still alive):

'I thought that people were telling me that I was horrible and killed my mother or sometimes that I harmed her in some way. As a result, I wanted to get my mum's medical records.'

She shared these worries with her CMHN and within their discussions about these worries she felt that she connected to the nurse's perspective:

'She gave me time and reassured me that... you know, as a teenager growing up we all fall out with our mothers; it made sense.'

It came across to SU5 that the nurse was interested and keen to help, and did not rely solely on biomedical explanations when answering. This fitted enough for her; she connected with what was said and the nurse. Therefore, showing interest, engaging in relevant issues, and making sense helps connection with each other.

Another factor that influences service users and nurses to attempt to connect with each other is previous positive less guarded communicative experience with a particular nurse/service user. N4 recalled working on an acute psychiatric unit where a female service user repeatedly tried to abscond; she wanted to get home. This lady had a history of multiple admissions, and was considered by some nurses to be the author of her own relapses; by taking her medication infrequently, and from their perspective choosing not to address certain chronic stressors at home. After another attempt to abscond she was being escorted to the seclusion room, but N4 intervened and suggested a different approach:

'She had made a run for it when she was down in the dining room and we had to restrain her and bring her back up to the ward, we were walking up the corridor and someone said 'seclusion', and I said 'no, I'll talk to her'.'

His decision to sit down and talk was based on previously meeting this lady in another context; when working as a CMHN he visited her in her own home:

'It is a whole different relationship when you are dealing with someone when you're walking into their home. I would always feel you're a guest in their home, where we would sit down and just talk about their family relationships and their worries.'

He thought that their previous communications had been open and useful. Therefore, past interactions meant he had a different understanding of her attempts to abscond; he knew that she worried about her son and husband, as they did not get on. Hence, when nurses and service users meet in the context of their own home, it is more likely to result in both connecting to the other's perspective as there is a balancing of power differences, where an equalisation of talking and listening is more likely to occur. N6 concurred:

'It's their home, so you can't tell them what to do. You can only suggest, advise, and listen. They are in charge of their own lives and have their own views. It's like we can hear each other better.'

When communicating in the context of a service user's home, power differentials veer towards the service user, and it is more likely that each person can connect to the other's story. This occurs as the nurse is mindful as a guest, to show respect for the service user's opinions. Hence, having a past connection that included lowering one's guard, allowed N4 to extend an offer to talk instead of just using seclusion, by transferring their previous less guarded conversations into the psychiatric unit.

Context was also important to SU7 as she was able to connect to her CMHN's perspective in a more meaningful way when they met either at a café or sometimes in her own home as she felt it put them on equal terms:

'You know, it's a funny thing, but I found that if we met for coffee we had better chats, now you wouldn't want anyone to overhear you, but it felt that I could take in what she was saying and vice versa. I didn't feel that really happen when I was in hospital.'

This redressing of power imbalance allowed her space to hear the nurse's perspective. Hence, meeting in a context that a service user feels comfortable in flattens any power differentials, which allow him/her to connect to the other's perspective and feel somewhat safer. The ability to connect to the other's story facilitates communications, to some extent, to begin to become less guarded, as both are able to see the other's viewpoint. In addition, other helpful factors are nurses promoting themselves as helpful, having past positive communicative experiences with a particular nurse/service user, as well as balancing of power differentials.

Nurses and service users also connect by being curious about each other's perspective regarding psychosis. This is not to say that nurses or service users abandoned the biomedical approach to psychosis, but they become curious regarding the substance and meaning of the other's story.

N1 recognised that she becomes curious about a service user's difficulties when she asks herself the question:

'Is there's something in it?'

In other words, is there some meaning, event or bases behind a service user's worries, even though N1 believed that the person is psychotically unwell? This wondering generates a sense of curiosity about possible connections between the delusion/hallucination and the person's life story, thereby, encouraging her to have less guarded conversations with the service user about his/her life, as it might be of help. N6 similarly developed a curiosity about service users' experiences and recounted a story of a woman who believed that she and her family were in hell:

'She said that everybody [her family] was in hell, but she and her parents would be able to get out of hell, but she couldn't get her partner out, and she was afraid to leave him behind. She wouldn't leave him behind; so they both had to stay there.'

However, as her story unfolded over the course of her admission, it seemed to her that this woman was living in an abusive relationship and her worries comprised of quite critical comments about herself and her parenting skills. This led N6 to be curious about possible links between the content of the delusion and the service user's relationship with her partner:

'It is interesting that she was saying that she couldn't leave him behind [in Hell], everyone else could come out of Hell, but he would be left there and she couldn't leave him behind, she'd have to stay with him.'

In other words, she wondered is there something negative happening in the service user's intimate relationship, but was too dangerous to speak openly about, which not only contributed to her psychosis but might be maintaining it? As a result, she began to consider having less guarded conversations as it might help. According to N6, this curiosity about a service user's illness story was often shared with other colleagues. N1 concurred:

'Sometimes we talk about it [content of delusion], and wonder might there be something to it.'

I wondered would they then become curious about other service users' psychosis or was it just that particular person:

'Well just that particular person. I remember there was a man who felt that he was the devil and he didn't love his wife because the devil didn't love anyone. His wife would be ringing every night distressed about the whole thing and we would kind of think really is there something in it? How could it be so fixed and nothing in it? Yet according to his wife he was a loving husband.'

'You see there is something around that, there might be something genuinely going on, and the delusion is fixed around this issue.'

Hence, her curiosity and interest in lowering her guard to enquire about the service user's story only extended to that particular service user and did not generally extend to others, where guardedness remained more raised.

Service users' curiosity about nurses' perspectives regarding their worries is mainly piqued when they realise that a particular nurse is trying to connect with them. The development of curiosity about the other's perspective does not occur in isolation; it usually happens before or concurrently with a nurse's attempts to connect or display interest in what was happening to them. SU1 recalled a time when she felt suicidal due to experiencing excessive stress as her negative voices had returned, and went to a crisis psychiatric nurse in a local hospital. Despite her previous negative experiences with another nurse, she felt that she not only connected with this nurse, but was interested in what he said:

'He treated me like an individual, not some number who came in. There was humanity in him, which speaks volumes without ever having to be stated. Sometimes you [nurses] don't have to have the five or ten pointers to deal with 'a schizophrenic', you know, they are human, and need to be treated the same as anyone else.'

This nurse came across as someone who seemed genuinely concerned about her difficulties, spoke in a way that was natural without an obvious distance and felt that she was not being objectified. There was also a normalisation of what she was experiencing by not putting it solely into the realm of psychosis, but yet acknowledging its impact. This influenced how she heard his perspective:

'He said that 'It's okay to feel very stressed out. You should take it easy on yourself and see what you have accomplished, you know, and decide where you are going'. Because at that point I couldn't see that I had anything of worth.'

As a result, of this connection and encouragement SU1 heeded what the nurse said, not only by not harming herself, but in deciding to reconnect with a nurse in her local day hospital.

SU9 had a similar experience. He too had felt quite stressed and rejected by some nurses when he tried to talk about his worries; he believed that his life was being portrayed on a popular soap opera, and wanted to sue the film company. However, became curious about a particular nurse's perspective after he felt the nurse was treating his concerns in a serious manner:

'He approached me and I told him about what was happening on the telly and that I wanted to sue them. He listened to me and said that he'll watch the program. That was the first time anyone said that.'

This offer created a curiosity in SU9 about what the nurse might say when they next met. The nurse later reported that he had watched that particular soap opera and according to him he said:

'Yes, there is a man around your age that has the same first name as you, and some of the things that happened to him have happened to you. However, it's is a really big corporation that is running the program and while you could try and sue them I don't think you'll get anywhere and it will cost you a lot of money.'

The creation of curiosity about the nurse's view came about by having his concerns being treated in a serious manner, which not only allowed SU9 to feel heard, it eased his desire to sue the soap operas producers. In addition, it gave him "hope" to go on, as he had being feeling despondent with thoughts of suicide. Hence, service users sometimes become curious about a nurse's viewpoint either after or concurrently being treated in a way that did not highlight the patient-nurse divide, where they feel respected, and their worries are somewhat normalised and/or treated in a serious manner. It is also interesting to note that despite previous unhelpful experiences, SU9 and SU1 remained open to making connections with nurses.

In summary, making connections occurs when participants are prepared to show curiosity about, and connect to, the other's perspective. These connections and curiosity are enacted

when some nurses seek to ease tense and difficult situations by emphasising their intent to be helpful, and by inviting the service user to recount their story. It is also more likely to occur when a particular nurse and service user have past positive less guarded communicative experience with each other in a community setting, or when a nurse displays interest and treats service users' concerns in a serious manner, in particular when power differentials are realigned. This allows both to begin to re-define what constitutes permissible communications between them, as connecting to and becoming curious about the other's perspective creates possibilities to be less guarded, where both are heard and understood. However, this it is often a tentative process where either one or both can raise their guard if deemed prudent.

Observing and Timing – Choosing a Safe Place

This refers to how the process of giving space and time to the other is seen as a powerful symbolic act, as it infers that each is considered worthy enough by the other to make space and spend time with them. It also carries the implication that one is choosing to make this space and donate time with a particular person rather than someone or something else. This is the second foundation stone that allows participants feel safe enough and trust the other enough to lower their guard.

As previously indicated, service users' decisions to become more or less guarded often depend on how nurses present themselves within their joint communications, so if interest and kindness are shown it is likely they will respond in kind. SU7 recalled, while hospitalised, some negative experiences with some nurses after requesting to talk and asking for a sleeping tablet. However, the following night she approached a different nurse whom she opened up to about her worries. I asked what was it about this nurse that influenced her to talk:

'Well, I approached a female nurse another night who seemed nice with the same request. The nurse listened and reassured me that 'nothing bad was going to happen' and I felt better afterwards; I was able to sleep. Sharing worries with someone is important; it lessened the burden.'

She was prepared to approach this nurse despite her previous negative experiences because she noted that the nurse appeared "nice". This judgement was made on her observations of how that particular nurse interacted and spoke with fellow patients. She called this approach:

'Watching the watchers.'

In particular, it was noted if: kindness is shown; the nurse speaks in a respectful way; he/she listens to patients' concerns; and they do not display an obvious hierarchical attitude. If these characteristics are not present, it indicates to SU7 a un-approachability, hence, these nurses are either avoided or communications are minimised with them:

'These nurses would be more hidebound. It's somebody who sees their job in a very much 'us and them' scenario, you know; very rigid boundaries and outlook. I mean there has to be very serious boundaries between patients and staff, but at the same time...'

'It [being hidebound] keeps a very severe distance between us generally speaking. Then the patients won't be trying to approach that particular nurse.'

When someone displays an obvious hierarchical attitude between nurses and service users, it impacts negatively on the potential of the service user to become less guarded with them. Hence, the service user chooses more approachable nurses to talk to. SU2 also observed how nurses behaved with other patients, and then approached particular nurses with a request to talk:

'I generally pick the nurses that were okay, that were alright about being approached about uneasy situations. You know friendly nurses that treat the other patients well.'

Therefore, service user participants note how nurses treat other patients and tend to approach those that they believe would listen to them, show kindness and respect. In addition, it is also likely that they lower their guard where pertinent questions are answered, and/or requests fulfilled.

In summary, service users try to make their communicative space safe enough by observing and choosing those nurses that seem approachable; show kindness, interest, understanding and respect. Alternatively, guardedness is raised with those that appear to give other patients little time, shows minimal interest in them as people, and/or display an obvious professional distance.

Nurses also took note of certain safety indicators when contemplating that it might be necessary and useful to become less guarded. N7 maintained that she would observe for certain indicators that it was safe enough to lower her guard:

'Well I usually would have seen them around the ward and noted how they got on with other patients, did they go for their meals and were they hostile with nurses. So if it was okay and they approached me, I would sit down and talk with them.'

It was noted how these service users interacted with other patients, their adherence to self-care, and any signs of hostility or aggression. If judged safe enough, she is prepared to be less guarded in conversation as her sense of risk of unintentionally causing hostility or making the psychosis more severe decreases. While N1 also took a similar approach, she placed more importance on the lack of obvious aggression:

'You'd keep an eye on their behaviour and demeanour, especially if they are angry or on edge. If they appear calm and relaxed I would be more likely to sit down and talk.'

Hence, the presence or absence of hostility or aggression is an important indicator that nurses observe for when deciding whether to raise or lower their guardedness. Another indicator is the apparent willingness of a service user to converse, either when they approach a nurse or vice versa. If they seem prepared to talk, nurses would initially engage them from a raised guarded context about general issues. N4 practiced this approach:

'First of all when they'd come up to me, I'd talk to them about something superficial. Then I'd see where I'd go from there.'

In other words, he keeps his initial conversations light, during which he tries to judge if the service user is responding in a way that he can understand; is it coherent enough? If judged appropriate, he is prepared to talk in more depth.

When talking to N6 about deciding to be less guarded with service users, the issue of insight was raised. Lack of insight is applied to those service users who seem to have a lack of awareness that they are experiencing psychosis, its impact on his/her functioning and the need for treatment. I wondered how she would know a person had insight:

'You know someone has insight because they'll say something like, 'Oh, I'm getting loads of those thoughts again' or 'those voices are there again'. You know through communication, they'll tell you, in their own way.'

'When people are admitted on a voluntary basis, they tend to have insight and they realise that they needed to come into hospital and that happens too...'

Therefore, if a service user is able to talk about their symptoms of psychosis in the third person, in a way that indicates that they agree that they are ill, and their voices, and certain beliefs are a product of this illness, for the nurse it points towards the fact that they have insight into their illness. So, if N6 thought a service user had insight it reduced the risks of engaging them in less guarded conversation:

'It is very good if someone can recognize that... they then would be able to talk about it. A person with insight can restrain themselves, 'cause they know if they're being given an order [hearing voices], they will be able to say, 'I'm being given an order'. Now they might find it hard to resist it, but they still say, 'this is still happening and I know that I'm listening to voices', you know.'

Therefore, it is considered by nurses that when a service user has some awareness that certain aspects of their thoughts and experiences are unusual, they then believe that the service user has the potential to control any aggression or hostility that might stem from the psychosis. As a result, the risk of unpredictability within their communications is judged reduced; it makes it safer. Consequently, to have or not to have insight was one criterion that many nurses observed for when deciding to lower their guardedness to service users.

Nurses also take account of the physical environment when attempting to create a safe enough talking space by initially choosing where to talk with service users. Hence, it usually occurs in a place within easy reach or eyesight of others, such as, a corridor, or when dispensing medication on an in-patient unit. If N4 believed that there were enough safety indicators he would invite the service user to enter a more private space to talk:

'If I thought that they were looking for something more in-depth from me... or they wanted to disclose something they were feeling at the time, and were responding okay to me, then I'd bring them into a room.'

Within this space both are able to attend to each other in a more exclusive way, which is likely to promote less guarded communications, as they could not be overheard or distracted. Nonetheless, this initial lowering of guardedness could be reversed if either came to believe that it had become too risky.

Another issue that contributes to developing safety and trust is the context of those communications. An approach some nurses use is to promote the hospital ward/unit as an overall safe place. When asked about attempts to make communications safe enough, N7 said:

'I'd make them feel safe in the environment they are in and not dismiss what they are saying. An example there lately was someone who thought they were going to be taken by scientologists. And I'd say, 'I know you think that's going to happen, but you are safe in here'. As he also worried that his file could be read by them, I explained the strict confidentiality they are kept under and showed him where they are stored.'

She tried to use re-assurance to emphasise that the unit/ward was a place of safety, a place where he and his personal information would be protected from harm. This approach also carries an implicit message of support and care. Hence, whatever their fears and worries are, the unit/ward is a place where they can be eased. However, N7 acknowledged that while service users' worries were eased, the overall ward environment at times became unpredictable and tense, thereby, somewhat negating her assertions of safety, which ran the risk of the service user raising their guard not only in response to the difficult ward environment, but because the nurse's promise of safety was unfulfilled.

Some service users stressed the importance of meeting in places of their own choosing (if not hospitalised). SU9 felt quite strongly about meeting his CMHN on "neutral ground". He was uneasy about the nurse calling to his home, as he felt he was being judged on his ability to manage his apartment and aspects of his life:

'I don't want someone to call to my flat, I don't want to sit down and think that this person has total control over my life; telling me how I should spend my money and make comment on how dirty the place is. I don't think that's recovery man. I don't click with him; I can't talk about stuff to him.'

His feeling of being controlled and observed impacted on his willingness to talk with this CMHN. He felt more on an equal footing if they met at a place of his choosing:

'I would like to meet my community nurse for coffee down town and not in my gaff, it's my gaff...It would allow me to say no and not to feel... to make decisions... you know, I'm easy bullied into things, from my background.'

SU9 believed that changing the location of their meetings would not only protect his privacy, but also empowered him to have choices, to either accept or reject any recommendations put forward by the nurse, no matter how well intended. Hence, identifying a safe space to meet is important, as both choose to go there and either could leave by agreement or by individual decision. It helps to equalise the power differential between them.

In summary, participants try to increase the likelihood of less guarded communications being safer by observing the other's propensity to respond in a helpful and safe way. To facilitate this process nurses note the absence of hostility, willingness to converse, ability to understand the service user's language, and showing some insight. Similarly, service users note how nurses interact with other patients, and seek to communicate with those who show interest, kindness, a non-hierarchical approach, and seem keen to help with particular concerns or issues. In addition, sometimes both choose what context to meet in to ensure safety. This happens in in-patients settings when nurses initially converse with service users near colleagues, then move to a more private space if felt safe enough, while service users, as out-patients, sometimes meet nurses in places where they feel safe and more in control. However, throughout this process guardedness remains present in case either's sense of risk increases, as each communication episode is judged on its own merits.

Another central process is showing a willingness to spend time with the other. This refers to making decisions to attend to the other in an exclusive way for a period of time, which implies that one is selecting to put time aside in order to listen and talk about issues both deem relevant. This process is recursive, as the giving of time makes it probable that it will reoccur. The importance of giving and receiving time was highlighted by SU5. She felt being given time by her designated nurse was significant:

'You could go to any nurse to ask for time, but the designated nurse was the best of all because they were supposed to give you time.'

I asked did her nurse give her time:

'Oh they did yea, if you needed it. I mean I wouldn't in general have been asking for time everyday by any means. But when I look for I got it. It helped my recovery.'

It helped because being given time when needed not only decreased her sense of loneliness, it allowed her discuss issues relating to her family from whom she had become estranged. The knowledge that her designated nurse was available to give time aided her recovery and eased her sense of burden. SU3 also valued his nurse spending time as he felt that his particular situation was understood:

'I spent a lot of time with her. I suppose we had a little bit in common too in that she lived in (name of city) for a while. She understood my situation, and that was good for me.'

'She was always willing to spend time with me.'

Nurses' willingness to give time to service users encourages them to give time back to the nurse, which has the potential to continue recursively. It promotes a positive anticipation towards these meetings, and carries a sense of safety and predictability.

Another aspect of giving time is the rationale behind why it was initiated. N5 felt it was important to give service users experiencing acute psychosis time even if they were not compliant with their prescribed treatment:

'So, for me it was more so about giving her time, listening to her, offering her reassurance, am... And I'd always tell her, I am here to talk and try to help even if you have doubts about the medication.'

This implied that she was willing to give service users time to discuss issues of relevance, even if they disagreed about or refused their medication and/or other aspects of their care plan. Thus, the giving of time to talk about issues of concern and hope is seen by some nurses as being as important as other aspects of treatment; maintaining contact and developing the nurse-service user relationship. It also implies respect of the other's opinions, even though they might disagree about some issues; it promoted a sense of reliability. Hence, the giving of time usually involves either service users or nurses making a request to get time from the other or receiving an invitation to give time. This is deemed an important step to making the other feel safe. It implies an interest and respect for the other, as they consider that nurse or service user important enough to spend time with, which in turn contributes to a sense of being heeded and valued.

In summary, *observing and timing – choosing a safe place* is seen by participants as an essential aspect of developing a safe enough less guarded talking space. They try to increase the likelihood of make more communications safer by observing the nurse/service user's propensity to respond in helpful and safe way, and based on what is observed decisions are made to engage the other in less guarded conversations. In addition, choosing the meeting context is also important as it increases the sense of safety of their joint communication, in tandem with showing a willingness and interest in giving regular time to each other. On the whole, these are important steps in creating a safe enough space both to engage and to continue less guarded communications. However, throughout this process guardedness

remains present in case either's sense of risk increases, as each communication episode is judged on its own merits.

Trusting the Other

This refers to how participants specifically build trust between them. It describes how increased trust embeds a sense it being of safe enough to stay less guarded with each other so issues of concern are likely to be addressed. Building trust in the other is mainly facilitated by keeping promises and by listening and responding.

The keeping of promises is an important process as it allows nurses and service users come to believe that the other will keep their given word, which encompasses and mainly applies to an action or a prediction. An action includes meeting at an agreed time or adhering to medication compliance, while a prediction incorporates assurances about recovery or one's availability. This process not only contributes to building a sense of security and trust in the present, but also facilitates participants to have an anticipatory plan or structure for future conversations. In addition, keeping promises enhances reliability regarding their relationship. This reliability includes an understanding that promises will be kept regarding meeting regularly, holding conversations about service users' worries and concerns, joint discussions about treatment plans, being honest with each other, and creating hope.

The initial part of promise keeping is making a promise, which refers to a nurse or service user giving their word that something will or will not happen. It states that they have agreed or given assurances to the other to do or give something to/for them, which usually includes an agreed time or time frame when it would be fulfilled.

In the early period of hospitalisation nurses tend to make promises to service users about issues of safety, their availability, and general intentions of helpfulness towards them. N2 advocated this approach, and would say to service users:

'I'm going to be looking after you.'

'You are in the right place; we are here to look after you.'

These promises not only referred to N2, but are also made on behalf of all clinical staff. The intent is to create an overall positive front regarding his and his colleagues' approach and intentions towards the service user, which carried an implicit assurance that their issues will

be attended to and they will be cared for. N3 agreed that is useful to give these promises as it reassures the service user that there is someone going to help him/her. However, he also includes promises of recovery:

‘Let them know that you are there for their good and their benefit, and, you’re there basically to get them well again, and get them back out into society.’

These are both specific and general promises to be of help and support in relation to their fears and difficulties, and to help them to resume their lives after the interruption of illness. Some service users not only experience these promises as positive, but find that it introduces hopefulness regarding their future. SU5 felt it was particularly helpful:

‘I remember I used to say to her [nurse] I’m not going to get through this, and she would say, ‘I have seen people like this and you will get better’. Because I thought ‘I’d be like this for a couple of years, I’m never going to get right again’. And she was saying, ‘you are’, and I was saying, ‘I know you have to say that to keep people going’, but it did keep me going.’

Despite being worried that promises of recovery might be said in an insincere way, it gave her hope that psychosis and its grip on her would loosen, which allowed her to keep going with her struggles with voices and paranoia. Hence, for her, hearing promises from a nurse was important. However, when general promises are made, for example, “we are here to look after you”, it has the potential to be problematic, in that, a nurse cannot be certain that all nurses will keep this promise. If this occurs, it is likely to dilute trust, especially when service users experience other nurses as too busy, or not interested in talking to them when needed.

Another aspect of making promises was giving guarantees on one’s reliability, such as agreeing to fulfil a practical request, or assenting to meet regularly. These pledges, when made, create a sense of interest and anticipation about forthcoming meetings. SU7 experienced this when her CMHN spoke to her about her availability to meet:

‘She not only said that she would call every week, but she gave me her mobile phone number so I could contact her if I really got worried. It gave me hope and confidence that she might be of help.’

It gave her a hope that the nurse was dependable and if needed would be available to meeting with her if she encountered difficulties. Therefore, making promises helps to enhance trust and a sense of safety between them. However, this trust can quickly dissolve if promises are broken.

Fulfilling promises is also part of promise keeping, which refers to following through on given assurances; it copper-fastens the trust that is initiated when making a promise. When this occurs, a nurse or service user is more likely to believe the other, or at least listen with respect and interest. It also introduces a sense of predictability about communication as both are able to anticipate that it is likely that future meetings or requests will be met.

Some service users experienced nurses keeping their word regarding being available to talk as positive and hopeful. SU6 recalled that it helped her through her hospitalisation:

‘Just I suppose it gave me emotional support, you know that somebody cared. Because as you know, it’s a very alienating experience when you are in hospital and I was there a long time.’

‘My nurse was always there when needed.’

Thus, fulfilling promises is important for some service users; it helps when struggling with difficult situations, as the nurse was available when asked for. So, trust is enhanced through nurses’ reliability.

Sometimes service users also make promises to nurses, such as agreeing to take medication. However, for a number of reasons some do not keep their promise either because they experience severe side-effects, or are insincere when making it, as they disbelieve the premise it is made on - that they are experiencing psychosis. SU4 stopped taking his medication as it made him feel worse:

‘I was completely whacked out; I was asleep most of the time and had some cramps or spasms, or something like that. I also had this sort of dry yawning all the time It was just a horrible, horrible existence.’

Even though he had initially agreed to take medication his experiencing of its side-effects changed his mind. This distrust in medication continued even when his medication was altered, which significantly reduced the unwanted effects. However, by extension he also lost trust in those who made the initial promises about its helpfulness. Hence, a difficulty for nurses in these situations is that not only do they make promises to service users to meet and be of help, they generally are required to try and ensure medication adherence. This places them in a dilemma: how can they keep their promises to those who reject or are not keen on medication as well as promoting medication compliance?

Some manage this dilemma by assuring service users, by words and deeds, that even though they believe that medication would be of help, it does not become the sole focus of their communications. N6 as a CMHN practised this approach:

'So, for me it was more so about, listening to her, offering her reassurance, am... And I'd always tell her, 'Okay, I feel medication would be of benefit, but that's not the only reason why I am here. I tell you how I feel but just because you don't want to take medication it doesn't mean that I'll stop calling'.

This implies a willingness to continue to engage and talk with the service user about issues of relevance, even if they refuse medication and/or other aspects of their care plan. Hence, for some service users, it instils and maintains trust that there will be ongoing support for their difficulties. As a consequence, less guarded conversations are likely to occur. On the other hand, promise breaking can decrease trust between them, so it is important from a nurse's perspective to try and not to make promises that cannot be kept. Thus, the keeping of promises is particularly important for service users because often they feel in a one down position in relation to nurses, both because some communication practices associated with *raising guardedness* and the impact of their psychotic experiences. Therefore, nurses keeping promises is significant as it helps to create a sense of trust and security between them.

Overall, the above process of making and keeping promises helps develop trust, which not only allows both to feel safe enough to be relatively less guarded and honest with each other, it also can facilitate the development of hope.

Listening and responding in a particular way also contributes to the building of trust between participants. It specifically refers to those communications that occur where both become more open to discuss issues each deem important. It includes attending to both verbal and non-verbal communications.

N1 recognised that her demeanour and what she said influenced how service users' reacted when in conversations with her. As a consequence, she was conscious of how she presented herself, either when offering to talk or in response to an invite. Her philosophy was that one:

'Gets back what you put in.'

In other words, if one appears dismissive and/or disrespectful, it is likely to elicit a similar response from the service user. Therefore, she used a more gentle approach:

'I'd go in with a soft approach.'

A soft approach meant appearing calm and relaxed, being aware of not invading service users' personal space and using a soft tone of voice. It also included smiling or in some way indicating a non-threatening intent. N4 also advocated this approach, but he included placing importance on how to start a conversation:

'What I found what you should do is... start talking about general issues. I know that nurses might be perceived of being... just laughing or joking or... or talking to them with no purpose. There is a purpose to everything we say, there is a therapeutic value. If it was okay, I would then talk about what was bothering them.'

As previously mentioned, initially conversations are kept light in the context of portraying a friendly non-threatening demeanour, which also contributed to connecting with service users. Then when judged safe enough, the nurse begins to discuss issues in more detail. One way they note that it is safe enough to talk, is when service users reciprocally respond and match nurses' non-threatening cues, and show interest in what the other is saying. When engaging a nurse in conversation, SU9 not only judged a nurse from afar but also within the conversation itself. He valued nurses that had a relaxed demeanour and showed interest:

'If they are calm and non-threatening I know I can open up, and if they listen to what I'm saying I'd probable ask to speak to them again.'

'Well, they'd be taking in what you're saying, you know, not like the nurse who started chatting about his personal difficulties. He may have thought this would be helpful; I certainly didn't want to hear about his problems.'

Therefore, when in conversation, he paid attention to the nurse's body language, tone, volume, inflection of voice, interest shown, and how they demonstrated that they were listening to his views. It is interesting to note, when service users try to articulate what influences them to become less guarded, most contrast past negative communicative experiences in order to convey the difference. Therefore, a nurse's use of a soft tone of voice, friendly expression and a relaxed body posture contributes to the process of both lowering their guard. In this way it is judged, both in the moment and from past experiences, whether to put trust in the other or not.

Another issue that some nurses focused on when listening and responding is the pace of their speech, and checking service users' understanding of what is said. This is believed important

as often the impact of the psychotic experience on service users' ability to attend to what is being spoken about can be compromised, in particular, if they were hearing voices and/or were more focused on internal conversations. In these circumstances N4 advised:

'You speak slowly; not because you're making them out to be impaired, but if someone is in a heightened state of elation or psychosis their thought process is mixed up. They might only hear three out of every ten words you'd say. So, you should say short concise sentences and paraphrase what they say back to them.'

In this way, it allows both the service user and nurse to pace their talk in a way that is useful for both, as well as to gently check-in and clarify understandings. Hence, each feels that he/she has been heard and listened to, and has created a style of talking together that could be used in future interactions. It also develops the use of a shared language that both understand. This was important for SU1 who felt strongly that nurses should not use unfamiliar words or acronyms:

'It's bad enough that you're dealing with all the stuff that's going on in your head, but when a nurse is mentioning CPN's, PRN's SHO's or chemical imbalances, you'd nearly give up. I tell them 'just talk in plain English please'.'

Thus, talking in plain English, joining the each other's language and creating a joint way of talking increases the likelihood of understanding each other's perspective.

Hence, when nurses and service users listen and respond to each other in a certain way it contributes to the building of trust between them. However, this does not happen in isolation but within the overall process of building trust.

Therefore, *trusting the other* refers to how participants specifically build trust between them, which embeds a sense it being of safe enough to stay less guarded with each other, which is mainly facilitated by keeping promises and by listening and responding in a way that promotes reciprocal trust.

Developing safety and trust refers to why and how participants develop a sense of communicative safety and trust between them. This is a necessary process for the development of less guarded and safe communications, which needs to be robust enough to tolerate certain anxieties and uncertainties associated with lowering their guard so issues of importance get addressed. In order for this to happen, both nurse and service user participants have to take a risk to engage in a more open way by displaying some willingness to make

connections with each other, in particular, by being curious about the other's perspective, which allows for the possibility to redefine what constitutes permissible communications between them to begin. However, for their less guarded communications to further develop both have to create a sense of joint safety and trust between them, which happens when they are able judge the approachability of the other through observation and conversing with each other, being comfortable with the communicative context, and an obvious keenness to give and accept time together. However, the development of safety and trust only becomes secure when promises are kept and both are able to listen and respond to each other in a way that promotes reciprocal trust. Therefore, the development of safety and trust is an essential aspect of *lowering guardedness* in order for a more open and deep communicative relationship to grow.

7.2.2 Conversing about Issues of Importance and Concern

This refers to those occasions when participants feel there is enough trust and safety present to lower their guard to communicate about issues that each deems important. In this context they endeavour to understand and discuss relevant issues that each deems significant, which has the potential deepen their relationship, ease distress and concerns and promote hope. Conversing about issues that each consider important is further described by *creating joint understandings* and *easing worries*.

Creating Joint Understandings

This refers to when participants are able to construct and share understandings about issues of importance, such as treatment plans, medication, worrisome experiences and life problems. This process contributes to maintaining less guarded communications about issues each deems necessary and useful to talk about, as it increases understanding of the other's position.

In this context nurses and service users share accounts of their own perspectives mainly through telling stories about current and past issues, the impact of psychotic experiences, and possible ways forward. Story telling involves an interactive process which conveys events in words and images that tries to give each other (to some extent) a sense of the other person's world. These perspectives include: current concerns, how they came to be, what they would like to happen, available help, risk, possible pathways to wellness, and hopes. The telling of stories allows more in-depth and extended (to varying degrees) communications to occur.

The sharing of stories usually begins with an invitation. Initially, some nurses and service users identified that physically “knocking on a door” is often how to start conversations to share views. N7 used this approach after by introducing herself if meeting the service user for the first time, then extending an invite to talk:

‘So, then you knock on the door and say, ‘listen do you want to chat for twenty minutes or for whatever length of time?’

The act of knocking on the door of a service user’s bedroom, or a service user knocking on the nurses’ office door seeking a particular nurse, intrinsically implies that he/she is seeking permission to enter into a conversation with the other, which is either accepted or denied. Hence, permission seeking acknowledges the other’s agency, and if accepted, instigates an increased sense of joint ownership regarding their impending communications. As indicated above, from a nursing perspective, if a service user declines the offer, the intent is to leave the possibility open for future conversations. N7 managed this by saying:

‘They might say, ‘no, go away from me’. And then you’d say, ‘fine, that’s no problem. But if you ever want to talk give me shout’, or ask them ‘is it okay if I come back later on to see how you are?’

The initial act of knocking on the door not only incorporates identifying herself, but it also implicitly or explicitly confirms/checks the identity of the other. Once communication commences, it usually begins with an open question from the nurse; such as, “how are you today?”, or a service user naming an issue, “I’m not feeling the best”, which both understand as only a brief inquiry, concern, or inviting the nurse to respond. SU8 thought that being approached by a nurse, and talking together, was an important step in getting to know each other:

‘Nurses asking me “how I am?” was good. That way, they start getting to know people; the way they feel and think and the way they looked like.’

So, getting to know the other contributes to the development of an understanding of the other’s perspective, as SU8 believed that it helped nurses to quickly realise and interpret that a service user was troubled or on edge, thereby, the help offered would be more relevant and timely:

‘He’d [nurse] know by what you say and how you look, meaning straight away like as he’d know you.’

Therefore, in the context of it being safe enough and trust a reciprocal process of talking, listening and responding occurred. This includes active listening, paraphrasing, and showing interest in the others story. SU3 felt that this approached encouraged him to share his worries:

'I just needed someone to sound out my case and listen, like. They're [nurses] interested. That was the whole thing being in the hospital, nurses used to listen fairly well without being judgemental or being pissed off or looking at you like you were crazy. That's how I used to start sharing what I was talking with them.'

It encouraged him to become more open towards the perspective of these nurses, especially about their interpretation of what he was experiencing, and was keen to continue to seek their views. N6 also saw the benefit of actively seeking the views of service users, as it created a space where she could respond in kind. She remembered one person she visited in her home who was experiencing acute psychosis. This service user was distressed about her house being bugged. During their conversation the service user sought her views about her worries:

'She'd say to me, 'do you really don't think the house is bugged?' And I'd say, 'If I genuinely thought that here was bugged, I'd ask that we go talk somewhere else.' And she'd be saying, 'But how can people know the things that I am saying and they aren't here?' How do they know out there what's going on here?'

The service user had become curious about N6's perspective and was keen to obtain her point of view as she had treated her worries in a serious manner, and as a result invited N6 to continue with their conversation. In other words, they begin to share stories regarding the service user's concerns. In this way, a familiarity occurs regarding each other's viewpoint, which contributes to a strengthening of trust. Another aspect that SU6 placed a lot of importance on was the consistency of nurses she talked with:

'You know, when different nurses are coming in and they come over and you're starting your story and it's too long to tell, you know, and they have only ten minutes anyway and you kind of say, 'I'm fine or whatever'.'

This inconsistency was compared with meeting regularly with a Clinical Nurse Specialist (CNS):

'So am... in that way it would have been different because... she would have known my story inside out, that sort of thing. She knew what I've gone through.'

The main advantage of having a consistent nurse is that the service user does not have to continually retell the story of his/her difficulties and related issues every time they meet, as the nurse becomes quite familiar with their difficulties and life story.

Overall, in order for nurses and service users to begin to maintain less guarded communications about identified issues of concern they need to share relevant stories that each deems important with each other. These stories include gaining permission to talk to each other, treating issues in a serious way, consistency of communication partner and being open to another's perspective.

Another aspect of *creating joint understandings* is having some awareness of one's own beliefs and feelings about topics under discussion, and at times being able to hold these beliefs and feelings in a state of temporary suspension. This occurs concurrently with the sharing of personal and professional stories, and increases the likelihood of the sustainability of less guarded communications so that issues of concern and importance are addressed in a more prolonged way.

An important aspect of this process is holding a view that psychotic experiences do not define the whole person. NU4 felt that one should not see the person just as an illness, and that recovery is possible:

'I think that for me, I think everyone can and does recover from mental illness. I don't think the illness defines them, I just think that they are unwell at that time. It doesn't mean that they are going to be this way forever.'

This allows him to see the person as someone who is currently experiencing a psychosis, which has temporally interrupted their life, and while they need help, there is a lot more to their life than illness. Thus, he used a wider lens than the bio-medical model on the person's life story, and imagined a place beyond their present predicament. It also introduced a flexibility regarding what was considered safe to discuss, which allowed a nurse to be less guarded about discussing various pathways to recovery. As already mentioned, service users feel strongly about not being treated as an illness/objectified. Therefore, when they experience being respected as a person (who is currently experiencing serious difficulties), it in turn encourages an increased curiosity about the nurse's perspective. SU7 recalled a nurse who listened to her worries and upsets and interacted with her about these concerns in a way that felt real:

'The nurse believed me about my experience of early and more recent bullying. She didn't dismiss me because of illness or that I'm a patient. She was good at listening, sensible, made sense, really genuine and treated me as a person.'

This nurse treated her as she would any other patient, addressed her worries in a serious manner, stayed with the conversation, and not just using general reassurances. SU4 concurred:

'I think what I like the most about it (talking to a particular nurse) is even though I was in an acute ward he still kind of treated me like as if I was someone he was talking to on the street. You know, an average person, not someone who is in a mental ward, because I was very aware of where I was and it didn't do anything for my self-esteem, You feel like you're ah... you've made a mistake somehow in order to end up here. That you've done something wrong or that you are a bad person to be in a psychiatric ward.'

Hence, it was useful to be able to communicate in a way that comes across as two people who could connect as human beings, who treat each other's issues in a serious manner, so as to give and receive help. This approach contributes to a sense of understanding each other's perspective when talking together.

In summary, *creating joint understandings* generates a space where participants share their own personal and professional stories enough to hear and understand the other's perspectives, when communicating together. These stories included gaining permission to talk to each other, using open questions, curiosity, consistency of communication partner, treating each other's issues in a serious way, and being open to another's perspectives. It is also helped by being able to temporally suspend any strongly held views on psychosis, thereby, reducing risk and increasing trust through having some sense of predictability about present and future communications.

Easing Worries

This refers to how participants focus on and engage less guardedly in conversations about identified areas of immediate concern and importance to both, which can help to ease concerns and difficulties, which occurs in the context of both feeling safe enough, and trusting the other and having some understanding of the other's perspective.

These less guarded communications usually begin by a nurse facilitating the service user to choose the initial topic of discussion. N5 thought that, unless judged too risky, the service

user should be given the opportunity to bring up their issues of concern. At the outset, some reassurance is usually given about being open to talk about these topics, by saying:

'Listen, I'm here for you, so if you want to talk about whatever is bothering you or even anything thing else, that's okay with me.'

Here, an invite and permission is given to be less guarded about his/her worries and issues, if they choose to, are introduced into their communications in the context of an explicit statement of goodwill. This approach encouraged SU8 post hospitalisation to share his worries and concerns with a nurse, as had been hiding his upset, fears and shame, not only about his beliefs that radio presenters were talking about him, but also about some of the things he done before being hospitalisation. However, he began to regularly speak to a nurse at a local day hospital:

'I felt that I could talk to her, she seemed to understand and help me tease stuff out, she didn't seem to judge me, you know. I felt it helped. These were hard things to talk about, you know, when I was really unwell I felt I was a huge burden on my family and tried to kill myself by crashing the car into a wall.'

This willingness to attain and maintain a less guarded stance about discussing difficult issues meant that they could share with each other an increasingly felt burden that was present for SU8 and explore ways forward together. Consequently, this occurred not only through sharing relevant issues with someone who seemed interested, but also by being able to reflect on and tease out worries from different perspectives.

N3 also felt there were times when focusing on areas of concern and importance could be beneficial to ease burdens when both are willing to communicate in a less guarded way. This was seen as important when service users are distressed about what he considers a delusion. N3 recalled a service user who believed that he was being pursued by scientologists, even as an in-patient, and he took the opportunity to talk to him about these worries during their third meeting:

'Well, lately there was someone (service user) who thought they were going to be taken by scientologists. He believed his chart had been taken by them, so I went through the procedure of confidentiality and that their chart will only be read by the staff on the ward, 'everything is perfectly safe you know'.'

His explanations were introduced as part of their conversation and said in a way that was understandable. However, it was not only what was said that was important, but that N3 displayed a keenness and openness to hear the service user's story as well. It encouraged the service user to approach him again:

'It gave him reassurance, but the thing about that is it left dialogue open between us. He would call me back into the room and say, 'look, I'm worried about this again'. At least he was talking to me, there were conversations and as their treatment progressed over a few weeks, I found that we, had a good relationship, you know.'

Hence, communicating in a safe enough less guarded way encouraged the possibility of future similar conversations and contributed to easing the service user's worries.

With regards to nurses approaching service users with an invitation to talk, on occasion service users approached nurses to talk with them, and this willingness to talk prompts a similar response from nurses. This can occur when a service user seeks help to ease a burden, in particular, when he/she is open to more in-depth discussions. SU1 had a positive experience with a crisis nurse in a local hospital and requested that she could meet him again to help her "fight" her psychosis. She had previously experienced reluctance from nurses to engage with her at this level:

'I needed the skills to fight psychosis, you know, how to control the voices and night terrors. So I wanted him to get down to the level of how it affected me psychologically and its impact on my life. Especially, how it had become a vicious circle at that time.'

However, despite the nurse telling her that he might not be skilled enough, she found their meetings beneficial as both were keen to discuss all aspects of her experience of psychosis. It not only helped to tease out different approaches to her difficulties, but the process of talking about her identified issues of concern aided her to manage the impact of psychosis while getting on with everyday chores of life.

Within these less guarded communications, space is also created for nurses to bring in their own issues of concern, as they are likely to be heard and sometimes heeded. N5 used examples from the person's own worries and life story when discussing and explaining the psychotic experiences to her. She spoke about a particular service user whom she talked to every day, who eventually asked her:

'What is a thought disorder and delusion?'

'I might say, 'do you remember the other day when you thought God was telling you not to eat because the food was unclean? Well, this was a delusion or a thought disorder. I then explained them in a bit more detail in a way he could understand.'

These explanations form a part of their overall communications, and are woven into conversations in response to a query or an apparent difficulty the service user is struggling with.

The use of a preamble in when communicating with service users is another approach nurses use in order to set the scene when attempting to ease distress or when giving difficult information. N6 used an extensive preamble before she expressed an opinion about a service user's mental health status, in particular, if she thought they were particularly lost in their psychosis:

'I would say, 'Look, I know you believe that and like I appreciate that you believe it. Then I'd say again, 'I appreciate... I understand that it's all real to you but I'm sitting here and I genuinely don't feel that the TV is talking to you. I really don't, but I personally think that you've got to the point where you are getting paranoid'.'

She felt that the advantage of this approach was that although they had a previous good relationship, she believed it necessary to emphasise to the service user that her views were important, but that N6 had a different understanding and needed to share it with her. Within this space of sharing issues of concern the service user was free to accept or reject this assertion.

Nurses also used a number of other approaches to try and ease service users' psychotic experiences. These approaches included using grounding questions and statements in the hope that it would ease worry or prompt service users to become critically reflective regarding their difficulties. N2 tried to carefully ground the person in the "real world":

'You would endeavour to enable them to get better, so you ground him, to bring him back to reality.'

Grounding meant seeking opportunities to introduce a different perspective regarding the service users' experiences, so that the service user would adopt it, or later, reflect on it, in a way that would contribute to easing or reducing his/her problems. N4 recalled a service user who thought that he was from the travelling community and his wife was not his wife. His wife maintained that this was all untrue:

'I went back to the past with him and tried to help him recall all the good times he had with his wife. How did ye meet? You have two nice kids and how are they? Are they in school?'

I wondered about his intentions:

'My intention is to create a little crack in the delusion. I think maybe remind him from the good times... to times when his feelings were different and maybe try and find when that changed.'

This approach was interspersed with talk about ordinary things, such as, issues about ward routine, making requests, different interests he might have. However, it was repeatedly brought up in conversations. What nurses called:

'Chipping away at the delusion.'

Some service users found this kind of communication helpful and sought out nurses who would engage them in this manner. SU2 valued this approach and sought out those nurses whom he knew from experience would engage him in this way, as he saw them as “part of the real world”:

'I know we would talk about my upsets but what I really valued was the ordinary talk. Talk about the hurling, about what is happening down town, you know real stuff.'

These conversations that included ordinary everyday events as well as addressing issues related to the psychotic experiences helped to ground him in a world that he had somewhat lost contact with, both because of the psychosis and hospitalisation. However, if the above approaches are introduced when shared understandings, safety and/or trust were not attended to, it risked that the service user becoming or remaining very guarded. It also risked the nurse becoming disheartened about their ability to ease the psychotic experiences as their interventions did not seem to have any beneficial effect, and raise their guard against trying to implement these interventions in the future.

However, being less guarded in communications did not always result in positive outcomes. N7 recalled a middle aged woman who was considered by people in her community to be eccentric, and had been hospitalised due her unkempt appearance, constantly talking to herself and sometimes appearing a danger to traffic. According to N7, despite the above she was content with her lifestyle and seemed happy:

'She was a lovely lady really but wasn't looking after herself the best. She spoke about how she liked to walk around the town and talk to people, and was very unhappy about being in hospital. She was also very open about the voices she heard, but didn't really mind them. She called them her 'friends'.'

After a period in an admission unit and taking anti-psychotic medication she stopped hearing voices. Though, according to N7, it seemed to make her life worse:

'Well, she had lost her 'friends', the medication slowed her down and she seemed to lose interest in things. The last I time I saw her she was living in a hospital supported hostel; she didn't go out much anymore. I often wonder would she have been better off if she didn't come into hospital or like a lot of them [service users] say nothing.'

So, being less guarded to nurses did not subjectively improve the quality of this person's life, in fact it appeared the opposite happened regarding losing her 'voices' and interest in life, where the nurse wondered would she have been more content if she kept her guard raised.

In summary, *easing worries* facilitates both service users and nurses to communicate in a less guarded way about issues of concern and importance. This includes giving permission to discuss these issues, addressing and discussing service users' felt burdens, identifying appropriate ways to manage difficult experiences, and conversing about different perspectives on psychosis. These less guarded conversations varied in length from being a one-off encounter to being part of an ongoing in depth nurse-service user relationship.

Conversing about issues of importance and concern is how participants are able to construct and discuss shared understandings about issues of importance and concern for both parties. This process contributes to being able to communicate in a less guarded and in depth way for varying lengths of time. Their communications mainly occur through the sharing of pertinent stories from each perspective, such as the impact of psychosis, hopes for the future, concerns about offered treatment, and problem solving. Therefore, through using words and imagery they both can conceptualise the other's world, thereby contributing to making that human connection which eases worries.

7.3 Summary

This chapter described the second sub-core category of *guardedness in communications* which is *lowering guardedness*, which means taking risks to engage in a more open and deep communicative relationship. This entails developing a mutual sense of safety and trust that allows both nurses and service users to engage in conversations about issues of importance and concern to both parties. In the main, the move towards being less guarded with each other occurs when participants feel that they need to take a risk regarding lowering their guard, initially tentatively, as they are keen to connect to the other in order to ease various worries and concerns in a more meaningful way. Risk is reduced by developing safety and trust between them by attending to and enacting certain safety indicators, where a willingness to give each other time and space to talk, that promotes joint interest and respect occurs. Simultaneously, trustfulness is created through the keeping of promises and learning how to talk and listen to each other in a less guarded way. When this takes place, nurses and service users proceed to converse about issues of importance and concern, to a lesser or greater extent. Therefore, in these circumstances, less guarded communications are able to ease distress and worry mainly due to respectful communications, connecting as human beings, understanding the other's perspective, addressing issues of concern, problem solving and creating hope. With regards to the context of where less guarded communications occur, they mainly happen in in-patient settings, day hospitals, out-patient clinics, the service user's home or a neutral venue. However, for varying reasons, lowering one's communicative guard occurs less often and is briefer in in-patient units. Overall, nurses and service users are able to construct a communicative space where it is permissible to lower their guard, that deepens their relationship and address issues of importance and concern in a way that they find meaningful. However, as guardedness is ever present in their communications *lowering guardedness* is always a temporary state as the degree of guardedness can be quickly change if either deems it appropriate or necessary.

Chapter 8. Discussion of the Findings

8.1 Introduction

The previous three chapters described the emergent theory *guardedness in communications between service users experiencing acute psychosis and mental health nurses*. The theory relates to how these service users and nurses in this study resolved or dealt with their worries, fears and hopes about establishing permissible communications by engaging in the processes of guardedness when trying to establish what was permissible to say. These processes are fundamental in understanding the complex interactional communications that occur when they engage with each other in a mental health care context, which gives them varying degrees of protection, ownership and choice regarding what is communicated.

This chapter will situate the theory within the wider literature. These discussions will represent not only the key issues that emerged from the theory but also issues that have significant implications for the practice of mental health nursing. The theory of *guardedness in communications between service users experiencing acute psychosis and mental health nurses* is explored in relation to the following key concepts ‘*therapeutic communications*’, ‘*collaboration*’, ‘*socialisation and therapeutic relationship*’, and ‘*trust and distrust*’.

8.2 Guardedness in communications as it relates to ‘*Therapeutic Communications*’

Within mental health nursing practice and research, engaging in communications that are therapeutic for service users, is considered a central aspect of nursing (Clarke 2012; Morrissey and Callaghan 2011; Stevenson 2008; Helm and Heggan 2004; Burnard 2003; Peplau 1987, 1952). The concept of therapeutic communications usually occurs in the context of therapeutic interpersonal relationships between a nurse and service users (Brown, Cashin and Graham 2012; Reynolds 2009; Dziopa and Ahern 2008; Cameron Kapur and Campbell 2005; Travelbee 1969; Peplau 1966). According to Barker (2009b), the overall intent of engaging with service users is to help them to explore ways of growing and developing, and how they live with and hopefully move beyond their problems of living. In other words, it is seen as helpful for nurses to communicate with service users about difficulties they are experiencing, with the intent of easing and/or overcoming them.

These therapeutic communication skills include listening to non-verbal communication, and summarising (Morrissey and Callaghan 2011); listening to verbal communication, building

meaning, exploring, prompting, self-disclosure, probing, comforting, reflective questions, and understanding the others perspective (Stevenson 2008); silence (allowing time for the service user to reflect), clarification, paraphrasing, informing and suggesting (Frisch and Frisch 2006). Therefore, it is considered that by engaging these communication processes it is likely that service users can cope better with their emotional problems, gain insight into their difficulties, facilitates positive behavioural change and can have outcomes for them (Hewitt and Coffey 2005; Stuart 2001; Peplau 1988). Some service users have reported that they do place value on their communications with nurses, in particular when they are listened to, and when nurses spend time and talking with them (Gilbert, Rose, Slade 2008; Russo and Hamilton 2007). Indeed, aspects of the theory *guardedness in communications* indicate that in certain circumstances this can occur, such as in Chapter 7 in the concept of ‘*developing safety and trust*’ where both lower their guard to begin spend time with each other and to talk somewhat more openly about issues of concern.

Yet, there are also criticisms of the conceptualisation of nurse-service user communications despite it being promoted as a good and helpful thing to do. A practical criticism is that the therapeutic communication aspect of mental health nursing is being eroded as delegated work within psychiatry becomes more prominent (Jones and Coffey 2012), work such as pharmacology, managing risk, administration and attendance at meetings; both clinical and managerial (Cleary et al. 2012; Higgins Hurst and Wistow 1999). As a result, a lot less time is spent in direct care to the detriment of service users (Goulter and Gardner 2005). Another difficulty is that despite expectations that that nurses develop and implement therapeutic communications skills, at times, both nurses and service users report unhappiness or frustration about their joint communications (Hem 2008; Koekkoek, Van Meijel and Hitschemarkers 2006, Duxbury 2002; Breeze and Repper 1998), such as, when service user experience nurses as poor communicators (McCabe 2004; Forchuk and Reynolds 2001), in particular when avoiding answering questions, ignoring them, and experiencing a lack of care, in the context of either minimal or paternalistic communications which leads to distrust (Coatsworth-Puspoky, Forchuk and Ward-Griffin 2006). Aspects of these criticisms are also similar to parts of the theory *guardedness in communication* where in Chapter 6 the concept of ‘*experience risk*’ speaks to service users raising their guard with nurses when they feel disrespected, objectified and/or to protect themselves from being placed in a vulnerable position. This point is also highlighted by Hewitt and Coffey (2005) who noted that there is a

belief among mental health professionals that those who are experiencing acute psychosis are unable to engage in therapeutic communications as they are too unwell.

Despite the above criticisms and difficulties, developing and implementing therapeutic communications is considered important in the service user's recovery process. In other words, there is a general notion that nurses' main 'raison d'être' is to help service users with their difficulties, and one of the foremost ways this occurs is through therapeutic communications. This generally happens by the nurse approaching a service user with the intent of being helpful, and the service user accepting this help so as to resolve or manage their issues of concern. This implies that giving and receiving help for difficulties associated with acute psychosis is nurses and service users' chief concern.

However, this perspective is not borne out by this study. Instead, it suggests that communications between nurses and service users who are experiencing acute psychosis facilitates some therapeutic benefit that is not as straight forward as the guidelines provided in the texts on this matter. In particular, it is a bit more conservative than the main concern of nurses and service users being able to provide and accept help, it is 'what is permissible to say and do at this moment in time?' when communicating together. It is the essential pattern that relates to how people deal with permissibility. This main concern is mainly implicitly shared by both parties where there is uncertainty about what communications are allowed, appropriate, beneficial or safe at a moment in time, as they do not want to place themselves or others in a vulnerable position. Hence, it is a complex fluid interactive process that needs to take place before and during their joint communication which is facilitated through the process of guardedness in communications. This process allows them to choose what to communicate to the other. This is not to say that giving and receiving help is not important, but it is not the central issue for nurses and service users experiencing acute psychosis when communicating with each other - it is what is allowed.

The concept of '*permissibility*' is relevant for service users and nurses in the following ways. For example, in Chapter 6, within the concept '*becoming guarded*' nurses have worries about making the service users' psychotic experiences more severe, while service users worry about loss of agency due to hospitalisation or social stigmatisation. As a result, when either approaches the other to talk, there are competing internal dialogues at play regarding what is permissible to say and do at that moment in time, which needs teasing out before any communications about other issues commence.

This process is important to articulate as it has a major impact on understandings of service user-nurse communications, as it appears it is an essential aspect of their communications; it provides a way to guard against the potential for miscommunication and misunderstandings. For example, when a nurse tries to therapeutically engage the service user in conversations or the service user is keen to talk openly about his or her distressing experiences, these attempts occur in the context of the other (or both) being uncertain what is permissible, which can lead to disappointment, frustration, and rejection. Therefore, this study suggests that in the absence of taking the concept of '*permissibility*' into account, attempts to engage in therapeutic communications with the other are likely to be unsuccessful.

In other words, on these occasions it works against the idea of the therapeutic communication. Therefore, in these cases, persons' acts are related to self and others' protection so as to gain a sense of some ownership and predictability through engaging in a process of employing guardedness in their communications with each other in order to work out together what is permissible to say and do.

In summary, the idea that the primary concern of ascertaining '*permissibility*', regarding service users experiencing acute psychosis and nurses joint communications needs to be taken account of when attempting to understand what occurs within their communications. Therefore, this study contends that this concept is an essential pattern that sheds light on the processes and understandings that occur when service users and nurses communicate together, which is resolved through the processes involved in '*guardedness in communications*'. Hence, it is an essential component of nurse-service user communications, which articulates the process from both perspectives, thereby, providing a more rounded perspective.

8.3 Guardedness in Communications' as it Relates to 'Collaboration'

Recently in mental health services in Ireland there has been a shift in focus to a more recovery, equality and collaborative practices approach with service users and their families (Cusack and Killoury 2012; HSE National Vision for Change Guidance Group 2010; Higgins and McBennett 2007). Involving service users and families in mental health care planning and decision making is central to current mental health policy (World Health Organisation 2012), where service users are seen as major stakeholders in service delivery and are considered participants in rather than recipients of mental health care (Goodwin and Happell

2008). Collaborative practices are also seen as empowering individuals to regain control over their recovery and care (Henderson et al. 2009).

An impetus that influenced the development of collaborative approaches was the consumer movements that began in the United Kingdom in the 1960's and 1970's, which focused on self-help and political movements that were linked with social action and developing a user voice (Ryles 1999). Concurrently, in the United States of America service users of mental health services began a movement using ideas of power, oppression and collective action to criticise and critique philosophies and practices of mental health services (Chamberlin 1977). In particular, it challenged an overarching paternalism that prevailed in mental health service, where clinicians' beliefs and attitudes dominated treatment decisions, which service users experienced as disempowering and sometimes abusive (Wilkin 2009; Henderson 2003; Barker and Stevenson 2000; Johnson and Webb 1995). Inger and Inger (1994) maintain that this is likely to occur in relationships where there is a status difference which is negotiated and constructed in momentary interactions. However, over time collaborative practices began to gain prominence in mental health care, which ultimately resulted in service users and families being promoted as partners with clinicians in the recovery process. For example, most Irish mental health services have consumer panels comprising of service user and family representatives, that contribute to policy development, speak to subjective experience of mental health care, and participate in the direction of mental health services (Inspectorate of Mental Health Services 2013).

Furthermore, the collaborative approach requires that nurses develop an alliance with patients that focuses on shared decision making/goals, open communication and a mutual sense of equality and partnership. It is also suggested that collaborative approaches within clinical relationships should articulate service users' and nurses' positive beliefs, values, and attitudes towards each other and their partnership (McCloughen, Gillies, and O'Brien 2011), and encourage nurses to address power issues through balancing the person's autonomy and providing support (Zugai, Stein-Parbury and Roche 2015). Hence, the concept of collaboration encompasses the development of agreed shared goals, where the nurse and service user work together to activate these identified goals through open communications.

Despite having a positive attitude towards collaborative alliances it continues to challenge clinicians to reorient their practice (Ness et al. 2015). McCloughen, Gillies, and O'Brien (2011) note that service users' and nurses' lived experience are disparate, which impacts on

their ability to understand the other, where issues of power are likely to have a negative impact on attempts to form collaborative relationships. In addition, there are challenges to the implementation of the concept of collaboration, in particular in inpatient care. According to Storm and Edwards (2010) and Bee et al. (2015) tensions can arise between service users and clinicians on treatment and care. These are issues that relate to risk and the person's capacity for user involvement, and concerns about what role service users themselves wish to play in decision-making, as clinicians worry about service users' lack of competence and awareness. In particular, newer care philosophies advocating service user empowerment continues to clash with more long standing approaches that rely on safety and containment. This seems particularly relevant for those who are experiencing psychosis as lack of insight is often given as a rationale for not engaging collaboratively with service users on their care plan (Bee et al. 2005), for example exploring shared decision making regarding anti-psychotic prescribing (Shepherd et al 2014).

With regards to the concept of '*collaboration*' this study suggests that service users experiencing acute psychosis and nurses are always guarded within their communications with each other, which implies that they never truly engage in the collaborative approach, as certain issues/opinions/concerns remain unsaid. Hence, one can never really know when meeting together with the intent of work collaboratively, how much both have bought into this approach. This is not to say that the nurse or service user is not interested in working in this way, where it seems they agree on shared decision making and goals. However, this study suggests that people might be using the concept '*keeping conversation light*' (Chapter 6) which includes the concepts '*playing the game*' and '*using reassurance*', where they keep hidden different agendas that work against the collaborative approach.

This occurs when service users and nurses appear to engage with each other in an open and collaborative way, but implicitly are guarded and strategic about what is said. Hence, while agreements on certain issues can be reached, their intent is just to say enough to avoid being placed in a vulnerable position, gaining an advantage or discovering useful information that is shared with colleagues. '*Playing the game*' is one approach that service users and nurses engage in when attempting to conceal and reveal signs and symptoms associated with acute psychosis. This is similar to findings by Sweeney et al (2014) where service users "play the game" (p. 9) so as to be discharged from hospital.

The service users at some point become aware that nurses are keen to assess their thoughts, feelings and behaviour with the intent of reporting their findings to nurse colleagues and psychiatrist, which can influence their treatment plans. For example, if hospitalised it could influence the length of stay and amount of medication prescribed. Hence, some raise their guard against revealing these signs and symptoms, and attempt to feign wellness. As an aspect of their role, nurses engage in conversations with service users with the intent of judging the content and intensity of these 'sign and symptoms' as a way to ascertain the effectiveness of treatment plans. However, they are aware that some service users try to minimise these experiences and use various strategies to reveal them, such as through observation and conversations where the service users would unintentionally reveal their experiences; the nurse is not up front about his/her intent. This is a dynamic and fluid process of concealing and revealing where they engage in communications with each other but are not forthright about their intentions and inner dialogues, in order to avoid being put in a more vulnerable position, being able to fulfil a task that is believed to aid recovery, and both avoiding any negative consequences. '*Using reassurance*' refers to nurses just saying enough to reassure the service users about worries or concerns and avoiding in-depth conversations, and the service users accessing this reassurance without having to reveal too much of their inner dialogue, thereby avoiding what they consider risky communications. Hence, there are times when service users who are experiencing acute psychosis and nurses engage in a process where they raise their guard against revealing their inner dialogue and intent, so that aspects of their communications are feigned in order to gain some advantage or avoid potential negative consequences.

In summary, this is relevant to nurses and service users when engaging in collaborative practices as either may think that they are working collaboratively, but as there are two actors involved each person only knows aspects of what the other person is bringing to the process. Therefore, the idea of collaboration has not, as yet, encompassed how the service user and nurse work out this intricate process of finding out how to work in a way that seems collaborative; intricate as one is never sure if the other is being authentic as guardedness is always present – where either person's communications can fluctuate from lowering to raising one's guard and so on, depending what is happening within their interaction and what is deemed advantageous to say or keep hidden. Therefore, this study suggests that this process needs to be taken into account, that there are two agents involved and the processes

that goes on between them, which includes the notion that at times either could believe it necessary to feign interest as other issues are deemed more relevant at that moment in time.

8.4 Guardedness in Communications’ as it relates to ‘Socialisation’ and ‘Therapeutic Relationships’

Within mental health literature the socialisation of nurses and service users and therapeutic relationships are usually presented separately. It is suggested that this study offers some way forward regarding integrating these two literatures in a way that could contribute to knowledge of practice.

Socialisation is a process where people obtain an identity, and learn roles, behaviours, norms, appropriate to their social position (Brinkerhoff, White and Ortega 2007), which occurs when people enter into a new social group (Berger and Luckman 1966).

Professional socialisation is considered important in contributing to the continuation of professional bodies by new recruits learning relevant skills (Faison 2003; Du Toit 1995). With regards to the socialisation of nurses Davis (1975) proposed a socialisation model that is known as “doctrinal conversion”, which articulates how nurses internalise the values, norms and expectations of the profession. Furthermore, Melrose et al. (2012) claims that professional socialisation is an ongoing process of gaining knowledge and skills that increases effectiveness for the profession. It also includes the internalisation of the behavioural norms and standards, and a bonding with those of the same profession. Hence, it provides newly qualified nurses a way to transition into the world of work and become part of a nursing team and the wider organization.

However, other studies suggest that junior nurses find this transition difficult where a high degree of adaption was required to be accepted by colleagues. Adaptations such as accepting the biological/biomedical ordination of the ward/unit and local customs and practices, where if they deviate from accepted norms they may risk exclusion from the group (Bisholt 2011). There is also a danger of newly qualified nurses becoming desensitised to poor practice habits and adopting them when they leave college and join professional nursing teams (Mackintosh 2006; Holland 1999). Indeed, Dimitriadou (2008) found that 91.8% of nurses found the transition traumatic as a result of the schism between what was taught in college and what occurred in the work area. This theory-practice gap may have serious implications for the nursing profession in terms of moral, job satisfaction and retention (Maben and MacLeod

2006). Therefore, in order for junior nurses to be accepted by the senior nurses they need to adopt and practice the current philosophical approach that prevails regarding mental health difficulties within the ward/unit. This professional socialisation process continues throughout a nurse's career.

Within this study concept of '*becoming guarded*' (Chapter 6) speaks to how nurses become guarded about communicating with service users experiencing acute psychosis, through observing, working with and modelling their communication and behavioural patterns. This helps them to demonstrate their ability and willingness to be part of the nursing group, and it eases their survival at clinical level (Mooney 2007). In particular, this study indicates that guardedness is introduced when there is a lack of approachability from senior nurses, thereby engendering fear of the unknown; being immersed in the biomedical approach to psychosis as the dominant approach to helping those with this diagnosis; receiving advice from peers on what to avoid, or not to do, when communicating with service users as they maintain it could result in the person's difficulties becoming more severe or becoming aggressive; being encouraged to talk to those who have a non-psychoses diagnosis (rather than those with a diagnosis of psychosis); and observing tense and difficult interaction between more senior nurses and service users experiencing acute psychosis. As a consequence, nurses are guarded when approaching service users to talk, as it affords them some protection against perceived difficulties.

Traditionally, the socialisation of service users is presented from the perspective of the impact institutionalisation had on them as initially articulated by Goffman (1961). He noted its impact of social withdrawal; where every aspect of the service users' daily activities occurs in the company of a large amount of people, their activities are tightly scheduled, their lives are dictated by institutional routine, they are isolated from the wider society, and they experience physical and social abuse with a corresponding loss of their previous identity. Wing and Brown (1970) found that institutional care often resulted in service users losing their independence and responsibility, and being unable to manage life outside the institution. In other words they experienced disempowerment. These and other reports prompted the deinstitutionalization of psychiatric service users into the community which began in the 1970's (Brennan 2014).

However, despite significant moves to provide the majority of mental health care in the community, as outlined in the mental health policy documents *Vision for Change: Report of*

the Expert Group on Mental Health Policy (2006) and *Psychiatric Services - Planning for the Future* (1984), service users continue to experience major difficulties, such as feeling stigmatized. According to Goffman (1963), stigma is an attribute that discredits the person and results in them being viewed by others as tainted. Indeed, people who experience psychosis are one of the most stigmatised minority groups within current society (Walker and Read 2002), and it is embedded in individuals' social system and the wider culture (Wood et al. 2015). This is compounded by service users' views of being not only ignored by people in their own communities, but also by mental health services and the media (Cain et al. 2014). For example, their personal stories are not attended to by clinicians, family or by the print and digital media, except with regards to medication compliance and risk. Indeed, Mac Gabhann et al. (2010) found that prejudice and discrimination continue to be experienced by individuals with a mental health diagnosis in Ireland. Hence, the stigma that people experience can result in them being considered dangerous, having a lower social status, avoidance from friends and family, and concealment of their diagnosis, which can lead to social isolation and low self-esteem (Pyle and Morrison 2014). Other studies reveal that people with mental illness experience negative and discriminatory attitudes from mental health professionals: these include blaming and critical and condescending paternalism, which can cause fear, secrecy and avoidance, decreasing the likelihood of developing therapeutic relationships/communication, and affecting the levels of trust needed to comprehend, assess and act to fulfil the needs of an individual (Farley-Toombs 2012).

This study speaks to this issue as the concept of '*becoming guarded*' (Chapter 6), which explains how service users initially learn to become guarded about what they say through experience or worry that they will be ostracised and discriminated against by people living in their own community: having a diagnosis of psychosis can carry a high personal cost, such as discrimination or being admitted to a psychiatric hospital against their wishes. Other, issues they encounter are being considered dangerous, undesirable and unemployable. Therefore, they are likely to live what McDaid (2014, p. 51) names "Shadow Lives" and are socially excluded where they live isolated, marginalised lives within their local communities. A case can also be made that a socialisation process occurs through experiencing psychosis. McCarthy-Jones et al. (2013) identified the theme of 'losing' when a person experiences phenomena associated with psychosis: losses such as loss of consensual reality, loss of coherent self, loss of hope and motivation, loss of security in body and world, and loss of

relationships and the pain that it causes. These losses can socialise the person into isolation, loss of confidence and self-esteem.

Therefore, these negative perceptions and low self-esteem influence them to keep their diagnosis guarded and secret to try and avoid ostracisation and discrimination. As a result, receiving a diagnosis of psychosis socialises service users to keep their diagnosis hidden to try and minimize the impact of stigmatisation, where their lived experiences and personal narratives are not easily spoken, and these concerns remain present when they communicate with nurses. Therefore, service users experiencing acute psychosis, and nurses, are already socialised to be guarded regarding communicating with each other even before they meet.

This section has given an overview of literature on socialisation of those who carry the diagnosis of psychosis, mental health nurses, and the process of how this occurs. The question is: how can this literature regarding the concept of socialisation link and be relevant to the literature associated with therapeutic relationships and communications for service users and nurses?

The mental health nurses and service users' therapeutic relationships and communication literature usually focuses on how nurses develop effective interpersonal and communication skills (Clark 2012; Morrissey and Callaghan 2011; Burnard 2003). The assertion is that by developing these skills it contributes to a service user moving beyond his or her problems of living (Barker 2000c). This process is considered both therapeutic and educational (Peplau 1966). Over the last forty years or more various concepts have been put forward to define what constitutes a therapeutic relationship, such as conveying understandings and empathy, accepting individuality, providing support, being there/being available, being genuine, promoting equality, respect, maintaining clear boundaries, addressing power issues, unconditional positive regard, and reassurance (Reynolds 2009; Dziopa and Ahern 2008; Chambers 2005; Peplau 1992, 1988).

Some service users place value on their interactions with nurses, such as when they feel listened to, talking together and spending time (Gilbert, Rose and Slade 2008; Russo and Hamilton 2007), experiencing a partnership approach to medication (Henderson et al. 2008), connecting at a human level (Deering 2004), feeling safe, respected and understood (Koivisto et al. 2004) and experiencing approachability, friendliness and empathy (Svedberg, Jormfeldt and Arvidsson 2003). However, as already discussed in '*therapeutic*

communications’ and *collaboration*’, at times difficulties are also present with nurse service user relationships and communications.

As already indicated, in *‘becoming guarded’* nurses and service users experience a socialising process before they communicate together, which influences service users to be reluctant to discuss their mental health difficulties and diagnosis, and nurses to be wary and apprehensive about communicating with service users. Furthermore, the concept *‘enacting institutional communications’* (Chapter 6) speaks to how they enact what is permissible to say and do in the context of existing institutional and personal communicative customs and practices. This occurs through nurses sharing of stories with each other about past and present communications with service users as well as their psychiatric history, and reading care plans. It provides a sense of validation from their peers as well as feeling part of a common purpose and group. Thus, nurses can be influenced by their peers to behave in either a positive or negative way with service users. Service users are mainly influenced by previous communicative experiences with nurses, nurses’ apparent lack of authority in decision making, introduced tensions by nurses into conversations, and at times an unwillingness to discuss in-depth their experiences related to psychosis. Therefore, they both mutually socialise the other to become guarded with each other.

Therefore, *guardedness in communication* speaks to the socialisation process that occurs for service users experiencing acute psychosis and mental health nurses. This socialisation process is ongoing (Melrose et al. 2012), contributes to gaining skills and becoming part of a group (Faison 2003; Du Toit 1995), but is also disempowering and contributes to marginalised (McDaid 2014; Mac Gabhann et al. 2010). This study addresses this issue through the concepts *‘raising guardedness’* and *‘lowering guardedness’*. *‘Raising guardedness’* provides some protection to those services users who are feeling disempowered, discriminated, have low self-esteem, and/or wish to avoid putting themselves in a more vulnerable position, as it gives them time to ascertain permissibility; thereby, gaining some ownership over what they reveal to mental health clinicians and others. It contributes to shoring up their sense of self. Nurses’ use of *raising guardedness* happens when they try and protect themselves by establishing what is permissible considering their belief that a service user’s behaviour is unpredictable and/or worry they could make the service user’s psychosis more severe. Within this context nurses and service users accept parts of therapeutic relationships, such as providing/receiving support, being there/being

available, and reassurance. This protection is delivered and accepted through *'keeping conversations light'*, which facilitates them to converse in the context of their guard being heightened. Therefore, the process of socialisation and therapeutic communications are applicable in *'raising guardedness'*.

As *'guardedness in communication'* is a process, raising and lowering guardedness is a continuum; hence it has the potential to quickly move from one to the other. So, lowering guardedness can occur as a facet within heightened guardedness or at times when it is somewhat more sustained. In order for guardedness to be lowered service users and nurses have to construct an implicit and explicit permissibility that includes measures that enhance their sense of communicative safety. Both parties use observation to judge the approachability of the other, conveying understandings, accepting individuality, being there/being available, promoting equality, respect, addressing power issues, and providing reassurance (Reynolds 2009; Dziopa and Ahern 2008; Chambers 2005; Peplau 1992, 1988). This sense of tentative safety is present when they converse about issues they both deem important. As above, issues of socialisation and the therapeutic relationship are present, but it can be argued in *'lowering guardedness'*, in the context of building a therapeutic relationship, a socialisation process occurs that allows the service user and nurse to converse more openly. As above, the process of socialisation and therapeutic communications are relevant in *'lowering guardedness'*

In summary, this theory *'guardedness in communications'* suggested that this study offers some way forward regarding integrating these two literatures in a way that could contribute to knowledge of practice. The literature on socialisation of those who carry the diagnosis of psychosis addresses such issues as how it come about both in society and mental health services, which can result in the stigmatisation of the person, disempowerment, discrimination and living an isolated life. The literature on the socialisation of nurses highlights both its positive and negative features: positive in the sense of being able to access and model nursing as it occurs in the world of work and becoming part of nursing teams; negative when these role models practice strictly biomedical approaches and disempowering interventions. The literature on therapeutic relationships is mainly accessed by nurses as guides to help service users. It is suggested that this study brings these two processes together as service users and nurses engage in the process of *'guardedness in communication'*, as it inform how they both become guarded and deal with communications together.

8.5 ‘Guardedness in Communications’ as it relates to ‘Trust’ and ‘Distrust’

‘Trust is a core professional value in nurses’ and midwives’ relationships with patients and colleagues.’

Nursing and Midwifery Board of Ireland (2015)

‘Trust was described as important in providing a positive experience and mistrust contributed to a negative experience of being an inpatient. Service users’ attributions of trust or mistrust were described only in relation to staff.’

Gilburt, Rose and Slade (2008, p. 6)

This study suggests that the concepts of ‘trust’ and ‘distrust’ are necessary aspects of communications between service users experiencing acute psychosis and nurses.

The concept of trust is described as a belief that our good will be taken care of (Pask 1995), or as an attitude bound to time and space in which one relies on someone or something (Johns 1995), and where there is a increased vulnerability and dependence in the truster (De Raeve 2002). Within mental health services trust is deemed important to those who are experiencing mental health difficulties as they have surrendered some personal autonomy to clinicians, in the hope of receiving care for their difficulties (Piippo and Aaltonen 2004). It is also seen as the main characteristic of the interaction between the service user and provider, and relates positively to service user satisfaction (Gaebel et al. 2014). Therefore, the development of trust is considered one of the more important attributes in developing a therapeutic relationship, as without trust, it is maintained that nurse-patient relationships remain superficial (Dinc and Gastmans 2013; Dziopa and Ahern 2008; Chambers 2005). In other words, a relationship that is built on trust is where the patient’s values are respected; is believed it can play a large part in creating hope and fostering recovery (Moyle 2003). De Raeve (2002) highlights the difference between trust as confidence and trust as reliance. Trust as confidence is where patients have a general trust in nurses that they have the skills necessary to be of help and will act in their best interest, while trust as reliance relates to making judgements on what others have done and will do, and if appropriate they are considered trustworthy.

Yet, Hem, Heggen and Ruyter (2008) claim that while the ideal of trust pervades nursing, it is distrust rather than trust that is prevalent in this area. Distrust is considered to be created when service users feel that clinicians try to pressurise them to make certain decisions or ignore them, and where treatment is rigid and bound to routines (Piippo and Aaltonen 2007),

while exploitation of unequal power in nurse-service user relationship is also considered to influence its development (De Raeve 2002). For example, a study by Chambers et al. (2014) found that service users hospitalised against their wishes experienced powerlessness and/or helplessness which resulted in distrust and decreased self-confidence. It is also noted that ethnic populations tend to have distrust in public mental health services as they perceive that they have/will experience unfair treatment by mental health services and staff (Henderson et al. 2015); other groups distrust the biomedical approach to psychosis (Bentall 2013; Bullimore 2012; Romme et al. 2009; Ross and Reed 2004; Breggin 1993; and Szasz 1970).

Developing trust with service users can create a dilemma for nurses. On one hand, they are encouraged to build and establish trusting relationships with service users as it promotes and supports recovery and helps them to become involved and have control over their treatment. On the other hand, service users often consider those nurses' attitudes and practices, such as risk management and medication compliance negatively, which is likely to increase their frustration, distrust, and possibly lead to conflict. Hence, establishing trust in nurse-service user relationships while deemed essential, can also present difficulties.

This study suggests that the concepts of '*trust*' and '*distrust*' are necessary and useful aspects of service users experiencing acute psychosis and nurses' communications. In particular, the concepts '*experiencing risk*' (Chapter 6) and '*developing safety and trust*' (Chapter 7) speaks to trust and distrust.

The concept '*experiencing risk*' refers to the process of services users and nurses heightening their guard with each other, due to mutual distrust. An aspect of this process is distrusting the other as it offers them some protection against perceived or experienced risks. This is articulated through the concepts '*enacting distrustfulness*' and '*experiencing hostility*'.

'Enacting Distrustfulness'

This occurs when both adjust their sense of what is permissible to say and do as they are distrustful of the other's motives or disbelieve the other.

Service users tend to become very suspicious of others when their inner conversations increasingly consist of worries about various conspiracies being planned against them and/or when experiencing critical voices. In addition, distrust is also created when they disbelieve the motives of nurses. When these patterns of thinking become dominant there is a

corresponding increase in their sense of risk and stress levels, with growing suspicions that they are being slandered, shunned, sometimes feeling under threat of assault or hospitalised. They become watchful and hyper-vigilant about what is happening around them, which includes what nurses are doing and saying. Thus, they judge it prudent to consider that generally communications with nurses are problematic and risky, and raising one's guard is necessary. In other words, service users can experience their communications with nurses as unpredictable and risky; hence raise their communicative guard and enact a process of distrustfulness. This is similar to De Raeve's (2002) assertion that one type of trust is 'trust as confidence' where one is confident that nurses are trustworthy. Consequently, service users who distrust nurses mainly as a result of their inner dialogue are experiencing 'distrust as confidence' where there is a general lack of trust in nurses.

Nurses also hold a 'distrust as confidence' regarding service users experiencing acute psychosis. Their distrust mainly relates to making judgements regarding the capacity of service users to engage in reasoned conversations due to the apparent presence of such experiences as delusions, hallucinations and distorted thinking. In particular, it occurs when a nurse believes that a service user has a significantly decreased ability to engage in meaningful conversations, as he/she is "too ill". As a consequence it is judged that service users do not have ownership over their own thoughts and behaviour. Hence, their opinions are not to be trusted. This is similar to the experience of nineteen service users and their accounts of their involuntary inpatient stays in the United Kingdom in Chambers et al. (2014), where they realised that nurses judged them to have lost control of elements of their behaviour and considered them a danger to themselves and others, which resulted in a joint distrust.

'Experiencing hostility'

This occurs when service users and nurses encounter hostility or threat of same and where communications are experienced as unpredictable and potential dangerous. Nurses worry about what they consider unpredictable behaviour of service users. Indeed, a report by the Department of Health and Children (2003) found that mental health nurses are at risk of being assaulted especially when working on an inpatient unit, while Duxbury (2008, 2002) states that service users can become verbally and physically aggressive towards nurses especially on inpatient units. Service users also worry about the potential/experienced hostility and aggression from nurses. Some have been forced to take medication against their will, been placed in a secluded room by a number of nurses, experienced severe side-effects

from anti-psychotic medication, and felt decreased personal agency which is experienced as traumatic. This usually occurs in the context of service users feeling confused, frightened, powerless, and experiencing strange phenomena (Chambers et al. 2014; Nijman et al. 1997). Hence, experiencing hostility reinforces their mutual distrust.

Therefore, raising their communicative guard in the context of mutual distrust is considered necessary and useful, as it offers them some protection against their fears, worries, and concerns about their own and others' safety. So, at times raising their guard is necessary and useful to deal with their distrust of the other. This can be considered as 'distrust as reliance' (De Raeve 2002), where distrust is created from experience and observation. While traditionally it could be argued that distrust results in superficial communications (Dinc and Gastmans 2013; Dziopa and Ahern 2008), this study suggests that it is an aspect of nurse-service user communications that at times is deemed necessary.

This study also indicates that at times service users experiencing acute psychosis and nurses can develop trusting relationships with each other for varying lengths of time. This refers to the process of lowering their guard as mutual trust increases, through the concept '*developing safety and trust*', (Chapter 7). This is articulated by the concepts '*observing and timing – choosing a safe place*', '*trusting the other*' and '*making connections*'. It also considered as 'trust as reliance' where trust is created from experience and observation.

'*Observing and timing – choosing a safe place*'

This process usually initiated when either one approaches the other with an invite to talk, or in the context of a more established relationship, and is more likely to occur in tandem with the concept '*making connections*'. In particular, it occurs when both parties are prepared to tentatively show curiosity about and attempt to connect to the other's story/perspective, each show some level of benign intent, have experience of past positive less guarded communications, have positive impressions of the other through observation, communicate in a community context, and treat the other's concerns in a serious manner. This has resonance with the ideas of Lloyd (2007) and Hem, Heggen and Ruyter (2008) on making connections and trust. Therefore, this process begins to allay any fear or concerns about being less communicatively guarded as the development of mutual safety and trust occurs, where they begin to connect with each other as fellow human beings rather than just a service user or nurse.

'Trusting the other'

The concept of '*trusting the other*' (Chapter 7) is another necessary aspect of '*developing safety and trust*' between service users and nurses. This occurs through the process of keeping promises and listening and responding to each other in a certain way. Keeping promises is important as it allows both parties to experience the other keeping their given word, which mainly applies to an action or a prediction. This not only contributes to building a sense of security and trust, it also assists them to have an anticipatory plan for future communication. Black (2016) concurs that promise keeping is important but that one has to be careful about one's ability to keep them. Listening and responding refers to constructing communications where both begin to be less guarded about discussing issues of concern and importance. This mainly happens through the implicit coordination by a service user and nurse when communicating together in the context of '*making connections*' and '*observing and timing – choosing a safe place*', in addition to listening and responding where both portray a non-threatening manner, are conscious of one's own personal space, adopt a soft tone, active listening, joining the other's language, and checking what is said. This displays to the other that there is interest in his or her personal and professional narrative, which allows trust to be reinforced.

In summary, with regards to '*guardedness in communications*' as it relates to '*Trust*' and '*Distrust*', this study suggests that both these concepts are necessary and useful for service users and nurses, and add to the understanding of the development and maintenance of mutual trust and distrust in their communications. This process occurs by raising and lowering guardedness which is relational and dynamic. It provides a sense of communicative protection, predictability and flexibility, which is similar to the assertion of Hem, Heggen and Ruyter (2008) that trust and distrust can easily tip over towards their opposites. Hence, trust can move to distrust and so on, even with a particular communication event, in response what is occurring at that time, both between them and within the internal dialogue of each. It also considers service users as actors that have influence in the development of trust and distrust, which needs to be taken account of regarding the theory-practice literature.

8.6 Summary

This chapter was concerned with situating some of the key processes and ideas embedded in the core category and theory into the wider literature so as to make the theory more rich and dense. The substantive theory from this study challenges some taken for granted ideas, such as that providing and accepting therapeutic communications are not service users' and nurses' main concern. Instead, their main concern is trying to ascertain what is permissible to say and do at that moment in time. With regards to collaboration, this study also suggests that as service users and nurses are always guarded in their communications with each other; they never truly engage in the collaborative approach, as certain issues/opinions/concerns remain unsaid. Hence, one can never really know when meeting together with the intent of working collaboratively, how much each has bought into this approach. This study also suggests that socialisation and therapeutic relationships can be integrated that can inform practice and theory. While the concepts of 'trust and distrust' are necessary and useful within the nurse-service user communications.

Chapter 9. Implications and Conclusions

9.1 Introduction

This chapter is the final chapter in the thesis. In the previous chapter the substantive theory '*Guardedness in Communications*' is explored and the chapter goes some way to establishing its worth, which can be understood and elaborated, and it implicitly challenges and adds to nursing practice.

9.2 Demonstrating Trustworthiness of the Study

Establishing what counts as trustworthiness is important in qualitative research (Cutcliffe and McKenna 2004). In the field of qualitative research there is a lot of literature devoted to establishing what is good research (Rolfe 2006; Lincoln and Guba 2005; Silverman 2005; Peck and Secker 1999). Yet, debates on the meaning of quality in qualitative research remain (Sandelowski and Barroso 2002). As a result, Spencer et al. (2003) recommend that quality criteria should be viewed as part of an ongoing debate, so they should be framed as guidelines rather than prescriptive rules. This section highlights the steps taken in this study to ensure the theory was developed by rigorous methods and thus is trustworthy. The most appropriate criteria for trustworthiness were judged to be those of Glaser (1978, 1998) and Glaser and Strauss (1967), by whom the quality of a grounded theory should be assessed. The criteria are fit, workability, relevance and modifiability. This section highlights the steps taken in this study to ensure the theory was developed by rigorous methods and thus is trustworthy.

9.2.1 The '*Fit*' of the Theory '*guardedness in communications*'

'Fit' refers to the substantive congruence of the theory, in particular, whether the categories and concepts sufficiently articulate the patterns in the data that they claim to conceptualise. With regards to 'fit' Glaser (1998, p.17) asks "Does the theory fit the substantive area"? So a CGT study has 'fit' if the concepts and categories are carefully developed from the data and not introduced from another theory or a from researcher's pet concept, which are not relevant. Within this study decisions about 'fit' were made through the research process.

'Data should not be forced or selected to fit pre- conceived or pre-existent categories in favour of keeping an extant theory intact. Our position is that the reality produced is more accurate than the theory whose categories do not fit, not the reverse.'

Glaser 1978 (p.4).

One way to judge ‘fit’ is to look at the researcher’s adherence to the methodology, such as the constant comparison method (CCM), which facilitates the development of categories that become more conceptual with the addition of new data in a systematic way. This process made sure that the theory was gradually developed. This researcher found it very useful in challenging his own biases which influenced him to introduce the concept of openness; however, by trusting the analytic process it became obvious that it did not fit. Another way to judge the congruence of the study is how well the core category addresses the main concern. This is answered by showing that the core category is abstracted from data indicators which show conceptualisation on the part of the researcher. The main concern of both nurses and service users experiencing acute psychosis in this study was conceptualised as *establishing permissible communications*, which captured the deep anxiety and fear regarding the process of what can be said and done, and not said and done when communicating together. The core category *guardedness in communications* describes a complex dynamic mutual process of moving through different degrees of guardedness in response to establishing what are permissible communications at that moment in time. Therefore, the theory particularly relates to the substantive area under study. It addresses how nurses and service users deal with the problem of permissibility through the process of guardedness.

In addition, to some extent the process of developing the theory and something of a trail of the analytic work can be accessed in Appendix D (p.237), E1 (p.241) and 2 (p.247), F 1(p.257), 2 (p.259), and 3 (p.262).

9.2.2 The Workability of the Theory ‘*guardedness in communications*’

Glaser (1998, 1978) maintains that the theory has to work to explain relevant behaviour in the substantive area under research. In the context of service users experiencing acute psychosis and mental health nurses this theory provides a way to explain and interpret what is going on in the substantive area. This point is made in Chapter 8 which articulates the contribution the theory makes to understanding the central importance of ascertaining communicative permissibility in service user-nurse communications. Collaboration – due to the presence of guardedness the ideal of complete collaboration is unobtainable as there are two agents that need to be taken into account and what goes on between them, and where certain issues/opinions/concerns can remain unsaid or interest is feigned. Hence, each person only knows aspects of what the other person is bringing to the process. Socialisation and therapeutic relationships - offer some way forward regarding integrating these two literatures

in a way that could contribute to knowledge of practice. Trust and distrust - both these concepts are necessary and useful for service users and nurses, and add to the understanding of the development and maintenance of mutual trust and distrust in their communications.

Furthermore, the theory *guardedness in communications* seems to offer understandings regarding certain issues in the context of service user and nurse communications. This includes finding ways to make their communications somewhat safer, showing flexibility in moving between lowering and raising guardedness, the ability to decide what is permissible to say considering what is occurring, how help is given and received in the context of the process of guardedness, and taking account of how nurses and service users influence each other in the construction of what they consider the appropriate level of guardedness.

In addition, the theory has identified behavioural patterns that service users experiencing acute psychosis and nurses engage in the substantive area: such patterns as learning guardedness, experiencing risk, keeping conversations light, developing safety and trust, and conversing about issues of importance and concern.

9.2.3 The Relevance of the Theory ‘*guardedness in communications*’

According to Glaser (1998, 1978) the theory has to have relevance for the people in the substantive area. Relevance relates to whether the theory developed is useful to the people in the substantive field, in that, it provides them with understanding and insight into the substantive area, by shining a light on previous embedded practices or hidden knowledge.

Relevance is evident if the perspectives of the participants are listened to, and the preconceptions of the researcher are avoided (Glaser 1998). Once the theory was developed, some mental health nurses and service users were consulted about it. Their feedback gave this researcher confidence that this seemed to be a useful theory to understand and question embedded communication practices between service users and nurses, thereby helping them to broaden their understanding about communicating with each other. One nurse said,

‘It makes me think about my conversations with patients that are psychotic and how I could do it differently’.

Another way relevance was established was through the CCM process regarding emerging concepts and including them in participant interviews during theoretical sampling. If the concept made sense or fitted for the participants it was retained, as ignoring its relevance

risked engaging in making decisions on their behalf. This researcher considers this theory relevant, as it articulates complex issues that can influence a wider audience and discourse with mental health nurses and service user forums on communication between nurses and service users, in particular, how both manage and resolve concerns about communicating together through the process of *guardedness in communications*.

9.2.4 The Modifiability of the Theory ‘*guardedness in communications*’

The final criteria for judging the study is modifiability. While Glaser (1998) is confident about the value of grounded theory, he is cautious about claims that could be made about it. As CGT’s are generated through inductive logic they are naturally modifiable, so one can infer from a single study/case that it can apply to other similar areas. These inferences are called tentative hypothesis in CGT (Glaser 1978). However, he also states that the theory is not verifiable - it is never wrong or right. Even when new data emerges it does not disprove the theory, but presents an analytic challenge to modify it (Glaser 1998). For example, if new data emerges that identifies different processes and strategies that service users and nurses use to when communicating together, the concept ‘*guardedness in communication*’ could be modified.

In addition, Glaser (2007) states that a substantive theory can become a theory that has general implications of a substantive core category, which is called a formal theory. This is generated from data collection and analysis in the same substantive area and other substantive areas. Thus, it is a conceptual extension. With regards to the substantive area of *guardedness in communications*, it could apply to other areas that where it is useful and necessary to be guarded in communications, such as the police, prison officers, barristers, and those who are experiencing domestic abuse, in addition to non-psychotic mental health problems, forensic psychiatry, and families and service users.

9.3 Some Reflections on the Study and Personal Learning

There were initial delays in starting the research process, particularly relating to obtaining approval from a regional ethics committee, as it seemed overly cumbersome and more orientated to those who are involved in quantitative research. Anticipating these delays in advance by talking to others who had gone through this process could have resulted in speeding up obtaining approval. Adhering to CGT in this study was both challenging and rewarding. When commencing the study the requirement of open mindedness was unexpectedly challenging for this researcher as his own preferred code initially came to the

fore when looking at emergent main concern and core category, with a temptation to bring premature closure to the process. This was resolved by adhering to the methodology and experiencing the research process, which helped to make sense of the data in particular through using the constant comparison method, memoing and theoretical sampling. Interviewing nurses and service users and gaining their perspectives on communicating together was interesting as most participants recounted their stories of worry, hope, frustration, struggles and a willingness to ease felt dis-ease. However, due to the delimiting nature of CGT a number of inquiry lines were deemed redundant, but are worthy of further research.

9.4 Limitations

The theory of '*guardedness in communications*' needs to be read in the context of the following issues:

- The study focuses on mental health nurses and current service users of mental health services who have experienced acute psychosis. Hence, the theory is limited to mental health nurses and service users experiencing acute psychosis.
- The study took a retrospective look from participants' accounts, which relies on them recalling their communications with service users or nurses.
- The findings are reported behaviours not obtained through observation. Therefore, there may be an element of bias when recalling events. As already discussed in the methods chapter (pg. 96-97), restraints were placed on the study by management in the research area that did not allow observation or interviewing service users who were experiencing acute psychosis due to concerns about capacity to give informed consent.
- The study was confined to one mental health service and volunteers from Shine support groups. Therefore, it is possible that this study reflects the culture within these two settings and does not fit nor is applicable to nurses and service users in other services in Ireland.

9.5 Implications for Practice

Researchers are asked to demonstrate the worth of their studies. This allows readers to be satisfied that the findings can be relied on to guide actions relating to the domains of practice, and to identify further area for research (Spencer and Ritchie 2012). Based on a review of the literature, this is the first study that attempted to explore how nurses and service users experiencing acute psychosis establish permissibility communications with each other, which involves the perspective of both groups. The emergent theory, which was conceptualised as '*Guardedness in Communications*', has a number of implications for action in the areas of clinical practice, education and research, which will now be discussed.

9.5.1 Implications for Nurses Working in Clinical Practice and Education

The theory of '*guardedness in communications*' has a number of implications for clinical practice. The theory suggests that nurses and service users try to establish what is permissible to say and do at a moment in time through the processes of guardedness. This has implications for practice as nurses are encouraged and expected to develop therapeutic relationships and communicate therapeutically with service users. This suggests that while components of developing these relationships and communications are articulated in nursing literature, it does not attend to concerns about what is permissible. Therefore, this study suggests that in nursing practice and education addressing the issue of these establishing what is permissible to say and do within therapeutic relations and communications is important.

Engaging in collaborative practice with all patients of mental health services is promoted, which includes mental health nurses. However, in the context of '*guardedness in communications*' service users and nurses keep certain issues and views hidden, thereby to varying degrees do not fully engage in collaborative alliances. This theory suggests that one never knows what the other brings to the process. In particular, the idea of collaboration has not, as yet, encompassed how the service user and nurse work out this intricate process of finding out how to work in a way that seems collaborative. Therefore, this study suggests that both perspectives need to be taken account of when developing practice guidelines for nurses.

The theory '*guardedness in communications*' suggested that this study offers some way forward regarding integrating the two literatures of socialisation and therapeutic relationships in a way that could contribute to knowledge of practice. The literature on socialisation of those who carry the diagnosis of psychosis addresses the issue of the stigmatisation of the persons who have mental health diagnoses, resulting in disempowerment, discrimination and

living isolated lives. The literature on the socialisation of nurses highlights both its positive and negative features: positive in the sense of being able to access and model nursing as it occurs in the world of work and becoming part of nursing teams; negative when this role models practices in a strictly biomedical approach and disempowering interventions. The literature on therapeutic relationships is mainly accessed by nurses as guides to help service users. It is suggested that this study brings these two processes together as service users and nurses engage in the process of *'guardedness in communication'*, as they inform how they both become guarded and deal with communicating together. Therefore, this study suggests that both literatures have relevance to clinical practice and education.

This study suggests that the concepts *'trust'* and *'distrust'*, are necessary and useful for service users and nurses, and add to the understanding of the development and maintenance of mutual trust and distrust in their communications. Hence, trust-distrust can tip from one to the other within a particular communication event in response what is occurring at that time, both between them and within their internal dialogue. It also considers service users as actors that have influence in the development of trust and distrust, which needs to be taken account of regarding the theory-practice literature and nursing practice.

9.5.2 Implications for Management and Culture of Mental Health Services

Considering that the practical side of nursing is formed and shaped within the practice environment, such as rehabilitation wards, acute units, psychiatry of later life, day hospitals and community settings, a solely educational approach to changing practice is likely to have minimal impact. Managers are important in setting the culture and accepted practices in mental health services, and can give clear messages and support on the importance of nurse-service user communications, in particular, the promotion of *'talking approaches'* as an aid to service user recovery, as the main approach to those experiencing acute psychosis is currently pharmaceutical and hospitalisation. As nurses are centrally involved in the care of service users both as in-patients and in the community, how they communicate with them matters, as other professionals learn to avoid engagement with them until they are judged *'well enough'*. Managers can support nursing staff by providing clinical supervision and further education (that includes the service user voice) for staff that will encourage them to engage in self, relational and theoretical reflections on their practice with service users and promote useful communication patterns.

9.5.3 Implications for Research

Overall, the literature review carried out for this study suggested that there is a multitude of studies on psychosis, communication models and practices that nurses can access, and advice how to interact with service users experiencing acute psychosis. However, research on how nurses and service users manage to communicate taking both perspectives into account is limited. While this study has commenced the process of research in this important area, it suggests a number of further areas for study, areas such as, observing in real time nurses and service users communicating together, and exploring whether service users' use of guardedness off-sets in any way their sense of disempowerment.

9.6 Summary

This final chapter attempted to demonstrate the study's trustworthiness, articulated some of this researcher's reflections on the study and personal learning's, its limitations, implications of the emergent theory for clinical practice and education, management and culture of mental health services, and further research.

This study was concerned with communications between nurses and service users experiencing acute psychosis and aimed to generate a substantive theory that could be used to inform practice. This study achieved this and offers a theory on how nurses and service users resolve or deal with establishing permissible communications through the process of guardedness when communicating with each other. It meets the criteria for a robust CGT study, as it discovered a grounded substantive theory, '*guardedness in communications*', which contributes to mental health practice. It is hoped that this theory will enable nurses and service users to communicate in a way that both feel is safe enough and to have some ownership over what to say when discussing issues each that deems necessary and useful.

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Appendices

Appendix A (1): Participant Information Sheet (for people who has experienced acute psychosis)

Research Study Title:

Exploring Communications between Nurses and People who are Experiencing Acute Psychosis?

Conducted by: The Carlow/Kilkenny Mental Health Service &
The School of Nursing, Dublin City University.

Principle Investigator: Sean Boland.

Supervisor Prof. Chris Stevenson
Tel: 01 7006581

Principle Researcher: Sean Boland
Tel: 056 7784401

Summary:

The study aims to gain a better understanding of the interactions between nurses and individuals that are experiencing acute psychosis. Therefore, the views and experiences of both nurses and people who have experienced psychosis within the last five years are welcomed. In order to inform nurses about appropriate ways to communicate with the person who is experiencing psychosis and organise treatment appropriately. Therefore, we would welcome your views about; 1) the key concerns and experiences of people who have experienced psychosis with regards to how they interacted with nurses when they were acutely psychotic; and, 2) what you consider to be a meaningful dialogue between these two groups.

Invitations to participate in the study are being made through a number of channels in particular mental health and support services. If you wish to respond to this invitation, you may still have some questions about what the study involves. Therefore, you will be offered the opportunity to discuss your questions and gain more information by talking with the principle researcher. For example, it will explained that with your permission the research meeting will be either audio or video taped and the meeting will last between 1-2 hours. You may then decide to take part in the research and if so another one-to-one discussion will be arranged with you. This discussion will be about: What are the ideas that you hold about psychosis?; How did these ideas come about?; How do these ideas influence your communications with nurses?; At what point(s) do you think the conversations got stuck?; What parts of the communications did you find meaningful and those that were not as meaningful?; How did the type of communications that you had with nurses influence your relationship with them.

Interviews will be held at a quiet and comfortable location as agreed between yourself and the principle researcher. Participation in this study is voluntary therefore you can decide to withdraw at any time during the study process. If you withdraw from the study you will not be discriminated against in any way and will be given equal access to information and

support services. Also if you decide to withdraw, any recordings of your research meeting that hasn't been analysed by the principle researcher will be destroyed.

If you present as acutely psychotic or suicidal during the interview the researcher will take steps to ensure your safety and well being. This will include; terminating the interview; directing you towards the appropriate service, for example, a professional with whom you are already engaged, or if you do not have current contact with a service you will be directed to either an A&E Department or your GP, which is the usual practice in such circumstances; the researcher will also contact the professional(s) with whom you are involved and / or an agreed other, for example a family member; and /or accompany you to the relevant service if this is deemed necessary in the interest of your safety.

Benefits and Risks

Potential benefits to participants include:

- Having the opportunity to voice your views and experiences to an interested person, which you may find helpful.
- Talking about your current needs and wishes and as a result deciding to become involved in a support service that you choose either to contact now or at a later date.
- Development of principles that will inform professional practice and service provision relating to the care of people who are experiencing acute psychosis.

Potential risks to participants include:

- You could become distressed in the interview by the recall of painful personal events and memories, which may lead to you requiring professional intervention.
- You might be assessed as indicating either acutely psychotic or a high risk of suicide and subsequently be directed towards professional services.

In the event that you become distressed during your involvement in the study process, you may choose to or be advised to discontinue and will be supported to avail of suitable support systems. Professionals involved with your care and treatment will be informed about your increased level of distress.

Anonymity and Confidentiality

Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

- Tape/Video recorded material will be kept by the principle researcher in a locked filing cabinet in a secure location.
- Only those working on the research team (principle investigator and researcher), will have access to this material, as they will assist with directing the project in the most useful way on the basis of emerging issues.
- Signed consent forms will be stored by the principle researcher in a locked filing cabinet, in a secure location and will not carry any identifying codes that connect individuals to specific recorded data.
- No information identifying an individual person will be used in documentation pertaining to the study. However, while there is little potential that any participant will be identified in any way, given the sample size is small it might have implications for privacy/anonymity.

- All material relating to the study will be destroyed once the study is completed.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

If you have any concerns about the conduct of this research project, you can contact:

The Secretary, Research Ethics Committee, Dublin City University.

Tel: 01 7008000.

Fax: 01 7008002.

Appendix A (2): Participant Information Sheet (for Nurses)

Research Aim:

Explore Communication between Nurses and People who are Experiencing Acute Psychosis

Conducted by: The Carlow/Kilkenny Mental Health Service &
The School of Nursing, Dublin City University.

Principle Investigator: Sean Boland.

Supervisor Prof. Chris Stevenson
Tel: 01 7006581

Principle Researcher: Sean Boland

Tel: 056 7784401

Summary:

The study aims to gain a better understanding of the interactions between nurses and individuals that are experiencing acute psychosis. Therefore, the views and experiences of both nurses and people who have experienced psychosis within the last five years are welcomed. In order to inform nurses about appropriate ways to communicate with the person who is experiencing psychosis and organise treatment appropriately. Therefore, we would welcome your views about; 1) the key concerns and experiences of nurses with regards to how they interact with people who are acutely psychotic; and, 2) what you consider to be a meaningful dialogue between these two groups.

Invitations to participate in the study are being made through a number of channels in particular mental health and support services. If you wish to respond to this invitation, you may still have some questions about what the study involves. Therefore, you will be offered the opportunity to discuss your questions and gain more information by talking with the principle researcher. For example, it will explained that with your permission the research meeting will be either audio or video taped and the meeting will last between 1-2 hours. You may then decide to take part in the research and if so another one-to-one discussion will be arranged with you. This discussion will be about: What are the ideas that you hold about psychosis?; How did these ideas come about?; How do these ideas influence your communications with people who are acutely psychotic?; At what point(s) do you think the conversations got stuck?; What parts of these communications did you find meaningful and those that were not as meaningful?; How did the type of communication that you had with people who are acutely psychotic influence your relationship with them.

Interviews will be held at a quite and comfortable location as agreed between yourself and the principle researcher. Participation in this study is voluntary therefore you can decide to withdraw at any time during the study process. If you withdraw from the study you will not be discriminated against in any way and will be given equal access to information and support services. Also if you decide to withdraw, any recordings of your research meeting that hasn't been analysed by the principle researcher will be destroyed.

Benefits and Risks

Potential benefits to participants include:

- Having the opportunity to voice your views and experiences to an interested person, which you may find helpful.
- Development of principles that will inform professional practice and service provision relating to the care of people who are experiencing acute psychosis.

Potential risks to participants include:

- You could become distressed in the interview by the recall of painful personal events and memories, which may lead to you requiring professional intervention.

In the event that you become distressed during your involvement in the study process, you may choose to or be advised to discontinue and will be supported to avail of suitable support systems.

Anonymity and Confidentiality

Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

- Tape/Video recorded material will be kept by the principle researcher in a locked filing cabinet in a secure location.
- Only those working on the research team (principle investigator and researcher), will have access to this material, as they will assist with directing the project in the most useful way on the basis of emerging issues.
- Signed consent forms will be stored by the principle researcher in a locked filing cabinet, in a secure location and will not carry any identifying codes that connect individuals to specific recorded data.
- No information identifying an individual person will be used in documentation pertaining to the study. However, while there is little potential that any participant will be identified in any way, given the sample size is small it might have implications for privacy/anonymity.
- All material relating to the study will be destroyed once the study is completed.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

If you have any concerns about the conduct of this research project, you can contact:

The Secretary, Research Ethics Committee, Dublin City University.

Tel: 01 7008000.

Fax: 01 7008002.

Appendix B

Participant Informed Consent Form

Research Study Aim:

Explore Communications between Nurses and People that are Experiencing Acute Psychosis.

Principle Investigator: Sean Boland.

Supervisor Professor Chris Stevenson
Tel: 01 7006581

Principle Researcher: Sean Boland

Tel: 056 7784401

Purpose of Study:

This study aims to obtain a comprehensive understanding of the experiences and perceptions of both of individuals that have experienced an acute psychotic episode and nurses who have provided care for someone that had acute psychosis within the last five years. Its particular aim is to look at the usefulness of communication between these two groups. This study will inform the provision of acceptable and relevant Mental Health Service in the Republic of Ireland and it is anticipated that this study will contribute significantly to existing professional knowledge and practice.

Participation Requirements:

If you wish to participate in this study, you will be invited to discuss with the researcher how appropriate it is for you to take part. This will involve talking about your readiness to discuss your personal experiences and the consequences that this might have for you at that time. This will assist you and the researcher to decide if participation is appropriate. If both you and the researcher agree that you should proceed to take part in the study, you will be asked to complete and sign this consent form and arrangements will be made for a one-to-one interview with the researcher. The interview will last between 1-2 hours and will be either audio or video recorded. If you do not wish to have the interview audio/video recorded, the researcher will take notes during the interview. You can decide the nature and depth of information that you share, and you may terminate the interview at any time without explanation. Participation is voluntary and if you choose to withdraw at any time in the study process you will be supported in this decision and will be given equal access to information and support services. No information identifying an individual person will be used in documentation pertaining to the study. However, while there is little potential that any participant will be identified in any way, given the sample size is small it might have implications for privacy/anonymity.

Please note that study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to

yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

Participant Confirmation:

(Please answer each question)

1. Have you read or had read to you the Information Sheet?

Yes/No

2. Do you understand the information provided to you?

Yes/No

3. Had you an opportunity to ask questions and discuss the study?

Yes/No

4. Have you received satisfactory answers to your questions?

Yes/No

5. Are you agreeable to having your interview audio/video taped?

Yes/No

Or Are you agreeable to the researcher taking notes during the interview?

Yes/No

Participant Signature:

I have read and understood the information in this form and the attached Information Sheet. The researcher has adequately answered my questions and I have a copy of this consent form.

Therefore, I consent to participate in this research project.

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix C

Interview Topic Guide

As Classic Grounded Theory methodology maintains that one has to be open to what is happening in the data, and that the researcher needs to follow it to discover the participants' main concern and how they continually process or resolve their concern the researcher needs to follow how they manage this as it is the substantive theory. Therefore, questions relating to this area cannot be formed in advance. However, the some big questions can be formed before interviews begin.

1. What is their main concern about communicating together?
2. How do service users experiencing acute psychosis and nurses' deal with manage or deal with their joint communications?
3. What influences them to decide to be more closed when talking together?
4. What influences them to become more open with each other?
5. What is their main concern about communicating together?
6. Considering that the service user has acute psychosis, does this influence their communications? If so how?

Appendix D: Raw Data (Participants perspectives), Initial Field notes and Open Coding

Initial Field Notes	Interview 6 Nurses 3	Open Coding
Afraid to dialogue.	<p>And....., that incident I would have kept reiterating, 'you know that not true', 'you know that not true', you know.</p> <p>But as time went on I would say, 'I know you believe that, but you are safe here and certain things cannot happen'.</p> <p>So, you know, I try and give them security from certain things that they think is going to happen.</p> <p>Rather than dismiss them out of hand.</p>	<p>'keeping the party line'. 'you're lying'</p> <p>'discounting the other'</p> <p>'acknowledging fears/cherished stories'</p> <p>'providing asylum'</p>
Why does he want to offer security?	S. What happened that you learned to change how you talk to people who are experiencing psychosis?	
Showing understanding about concerns helps in making connections.	<p>J. I believe that I couldn't communicate with somebody if I didn't try and think at their level. They would dismiss me out of hand and they become paranoid about me.</p> <p>And in that incident I became another British agent and there was no dialogue between me and the patient then.</p>	<p>'connecting with an other's story' 'treating them with respect'</p> <p>'showing interest'</p> <p>'dismissed out of hand'</p> <p>'significant learning point'</p>
You are another human being just like me.	<p>S. So, if you thought the patient was thinking, 'This guy is not listening to me, he would just dismiss you?'</p> <p>J. Yea, yea.</p> <p>S. And the new way, what are you doing again?</p>	
Reassurance – I hear you and understand why you are worried, but you are safe now. We'll protect you.	<p>J. Am....., I'd make them feel safe in the environment they are in and....., not dismiss what they are saying. Ahh....., an example there lately was someone who thought they were ah....., going to be taken by scientetologists. And I'd say, 'I know you think that's going to happen, but you are safe in here'.</p> <p>He thought his chart had been taken by scientetologists, so I went through the procedure of confidentiality and that. Their chart will only be read by the staff on the ward, 'everything is perfectly safe you know'.</p> <p>S. Okay, and what did the person say back to you?</p> <p>J. It gave slight reassurance, but the thing about that is it left dialogue open between us. And he would call me back into the room and say, 'look, I'm worried about this</p>	<p>'Creating a safe enough space'</p> <p>'Addressing worries'</p> <p>'Context reassurance'</p> <p>'Addressing specific concerns'</p> <p>'Promising security'</p> <p>'leaving the dialogue door open'</p> <p>'Anticipatory dialogue'</p>

Meaning of reassurance? Why do they need reassurance? Why do they have to give reassurance? Dialogue-a door that swings both ways	<p>again'. Ah....., at least they were talking to me, there were conversation and....., as their treatment progressed over a week....., I found that we....., ah....., had a good....., you know, we'd have a good relationship and when.....</p> <p>S. Okay, can I stop you there because I want to back to go back a bit. Remember you said that it would reassure them a bit?</p> <p>J. Yea.</p> <p>S. How did you know that?</p> <p>J. Am....., probably just through....., you can see someone settling a bit. They are not as anxious, they're..... As I said, this guy was running at the door, trying to get out of the ward. And ah....., you know. Now certain staff members said....., (hesitant) 'seclusion', you know. Ah....., which....., you know, really I felt it was the wrong thing, you know..... That ah....., you're locked in a room and you are left with your fears and you can do nothing about it.</p> <p>But if they had a chance to talk....., ah....., and....., it....., and the person did settle after a while.</p> <p>I would have looked after this person in the community as well. I would have called to their home, so....., ah....., so, I thought myself that it would be better talking to the person than throw them into the room....., was not the answer.</p>	<p>'not dismissed' 'developed good relationship'</p>
Professional relationship across different contexts influences interactions as an inpatient.	<p>S. so, the fact that you knew them before did that help your relationship on the ward/</p> <p>J. Ah....., it did a bit because it is a whole different relationship when you are dealing with someone, say when you're walking into their home....., I would always feel you're a guest in their home.</p>	<p>'Settling patients' 'Reducing anxiety' 'Some staff advocate seclusion' 'disagreeing with seclusion' 'Seclusion shuts out dialogue' 'cannot reassure fears'</p>
Being a guest in someone home you are more likely to treat them with respect and what they say with respect.	<p>Where as when you are dealing with them on the ward, they feel you are the one in control ah....., you know, that a certain amount of power has been taken off them.</p> <p>S. So, you have more power, more obvious power, and they fell more disempowered?</p> <p>J. Yea, yea.</p> <p>In those situations I have to try and am....., you know.....,</p>	<p>'A guest in their home' 'comparing outpatient and inpatient work'</p> <p>'Conscious of power imbalance' 'Powerful nurses'</p> <p>'Neutralizing power'</p>

<p>This relationship/way of interacting is carried forward to the inpatient setting and back out again.</p>	<p>try and....., maybe neutralize that....., and bring it more to the relationship we have outside because....., you know, I'm going to be dealing with these people again outside, you know.</p>	<p>imbalance'</p>
<p>'Setting context and pointers for meaningful dialogue'</p>	<p>S. And how did you manage that?</p> <p>J. Well, just in general sitting down and just talking, now....., it would need to be for a long time and talking about the problems we would have been discussing in their own home , and talking about their family relationships. And you know, bring her back to what triggered it. You know, 'things were going well and what happened?'</p> <p>Which is the way I would have approached it if I was in her home and we talk about their stay in hospital, ah....., you know. A lot of people would have fears and..... (pause)</p> <p>S. Reassuring them in relation to their fears about their stay in hospital?</p> <p>J. Yea</p> <p>Now as I say....., am....., you're probably....., you know yourself working on the wards, some people are very much....., if patients give trouble....., get them out of the way, you know.</p>	<p>'Sitting down and talking' 'long conversations' 'Discussing relevant worries' 'showing interest' 'Tell me your story'</p> <p>'talking as if you were the guest' 'knowledgeable guest' 'allaying fears'</p>
<p>Recognized that some nurses have little interest in talking to 'troublesome patients'. They take a dislike to them – blame the patient, there under false pretences, influenced by other staff? Especially for people who come in regularly.</p>	<p>S. Put them in seclusion?</p> <p>J. Yea, yea.</p> <p>S. Okay, in regards to this particular patient you are talking about, you knew him and you had an idea what might be a helpful way to help him through a difficult admission, but you say other nurses had different ideas.</p> <p>J. 'She'</p> <p>S. Oh, it was a woman.</p> <p>J. Yes.</p> <p>S. Okay, in the nursing station, what kind of things were being said about this patient?</p> <p>J. Am....., (pause) Well, she would have been a regular</p>	<p>'Advocating seclusion for troublesome patients' 'get them out of the way'</p> <p>showing intolerance for regular admissions 'oh, she's in again'</p>

<p>Nurse managers/ senior staff have a strong influence on the ward ethos. How generally nurses interact with patients – through modelling, direct orders, disregarding feedback/views from nurses who spend time with patients.</p>	<p>coming in. So, certain....., certain staff would have an intolerance to....., they'd remark, 'oh, so she's in again', 'She was only only gone a few weeks'</p> <p>Now the majority of staff wouldn't....., you know, they'd like the person. They'd....., ah....., (pause) again..... I think some fear that, 'well, there is nothing we can do for this person', 'this is ongoing and it happens all the time', you know. Am.....,</p> <p>S. So they were frustrated?</p> <p>J. a bit frustrated and....., in some cases ah....., they were apathetic to the whole thing.... you know, they didn't care....., now this would be one or two of the staff, you know.</p> <p>S. With regards to those people who came in quite often. What do you think some nurses that didn't care....., what do you think is behind that?</p> <p>J. Ah....., in some cases I think it could be boredom....., a very small element. In certain situations these people are calling the shots there.</p> <p>S. They are in positions of power?</p> <p>J. yea.</p> <p>S. Would that mean that their opinion would carry more weight that junior staff nurses or staff nurses in general?</p> <p>J. Well, again I've seen a big difference over the last eight years since I started. Before it was....., but now I see junior staff are speaking up more.</p>	<p>'To like or not to like'</p> <p>'fear of being seen as not helpful'</p> <p>'Some nurses don't care'</p> <p>'bored nurses in senior positions'</p> <p>'junior staff are speaking up more'</p>
<p>Third level students are introducing a more positive change. Making their voices heard.</p>	<p>S. Okay, why is that you think?</p> <p>J. Am....., I honestly....., I don't know whether it's the fact that they are....., the training now they go through. And I know I trained under the Diploma and we were told all the time, you know, 'the patient was first, the patient was first', Question, question, question always'.</p> <p>So....., and I know it's gone onto the degree now and talking to some of the students now, they are encouraged to question especially if they don't agree with them (senior staff). And I've seen some situations were students are questioning certain decisions.</p>	<p>'Students trained to voice opinions'</p> <p>'putting patients first'</p> <p>'Encouraging curiosity and assertiveness'</p> <p>'balancing old and new practices'</p>

Appendix E (1): Raising Codes to Higher Conceptual Levels

Interview 6 Nurse 3

To like or not to like (p. 4)

- Carrying negative or positive stories (p. 6)
- Seeking Hospitalization under false pretences. (p. 6)
- Wasting nurses time. (p. 6)
- Being influenced by stories told and carried (p.6)

Oh, she's in again

- Showing intolerance for frequent admissions. (p.4)
- Blaming them for being ill (p.17)
- Giving up on them. (p.17)
- Some staff not caring care (p. 4)

Settling patients (p. 8)

- Settling takes time (p.8)
- Medication settling them (p. 9)
- Settling of the mind (p.14)
- Settling happening within a week (p. 14)
- Resting the whole body (p. 14)
- Reducing anxiety (p. 3)
- Settling by reassurance (p. 3)
- Obtaining peer validation (p. 3)
- Fearing peer criticism (p.5)
- Calming the psychotic patient (p.8)
- Trying to ease worries (p. 13)

Promising asylum

- Promising security (p. 2 &13)
- Creating asylum (p. 2)
- Feeling safer (p. 6)
- Making people feel safer (p. 8)
- Creating a sense of safety and comfort (p. 12)

Promising recovery (p.8)

Why psychosis visits

- Cannot cope with life (p. 11)
- Increasing use of drugs (p. 11)
- Susceptible young men (p. 11)

Knowing what you are dealing with (p. 1)

- Being in a psychotic state (p 1)
- Dealing with a psychotic mind (p. 1)
- Medical categorisation of beliefs (p.. 1)
- Categorising carries action plans (p. 1)
- Major mental disorder (p.11)
- Triggered by cannabis (p. 11)
- Many aspects to psychosis (p. 11)
- Obtaining a little history (p. 12)

Easing pain and torture (p. 14)

- Sedation helping them out of psychosis (p. 11)
- Sedation helps (p. 13)
- Seriously successful (p. 14)

Journeying to Damascus

- Eventually will see the light (p. 17)
- Prodigal son's of psychiatry (p. 16)
- Trying to win them over (p. 17)
- Lacking insight (p. 17)

Difficulty gaining compliance (p. 16)

- Feeling well leads to non-compliance (p. 16)
- Taking medication stops admissions (p. 17)
- Being non-compliant doesn't work (p. 16)

Taking the bitter pill

- Don't like it, don't want it, but need it (p.5)
- Introducing foreign chemicals (p.16)
- Refusing to take it. (p.5)
- Disbelieving nurses (p.17)
- Openly defiant (p.5)
- Experiencing unpleasant side-effects (p.16)

Being Honest with nurses (p.5)

- Reaching Compromises (p.5)

Balancing chemicals (p. 14)

- Believing no other option but medication. (p.14)
- Engaging in a battling against illness (p.14)
- Seriously successful (p.14)
- Considering older medication more helpful (p.9)

Acknowledging medication doesn't always work (p.15)

- Unsure why it doesn't work (p.9)
- Body and mind rejecting medication (p.14)

Cultivating Dialogue

- **Sitting down and talking** (p.3)
- Sitting down and giving time (p.12)
- Hour long talks (p.6)
- **Tell me your story** (p.4)
- Acknowledging fears/cherished stories (p.2)
- Connecting with their story (p.2)
- **Discussing relevant worries** (p.4)
- Addressing worries (p.2)
- Discussing life stressors (p.6)
- **Showing respect** (p.2)
- Imagine you are their guest (p.4)
- Knowledgeable guest (p.4)
- Showing interest (p.2 & 4)
- **Creating a 'safe enough' space.** (p.2)
- **Leaving the dialogue door open** (p.2)
- Anticipatory dialogue (p.2)
- developing relationships (p.2)
- **Validating the positives** (p.7)
- Awareness of home life (p.3)

Normalising conversations

- Discussing areas of interest (p. 12)
- Reducing psychotic talk (p.12)
- Breaking line of thought (p.12)
- Increasing rationality (p.6)
- Revealing trigger events (p.6)

Companions on the recovery road

(p.17)

- Struggling together (p.17)

A guest in their home (p.3)

- Increasing awareness of power imbalance (p.3)
- Neutralizing power imbalance (p.3)
- In-patient, out-patient relationship (p.3)

Aiming high

- Striving for wellness (p.16)
- Normal functioning (p.16)
- Contentment (p.16)
- Being independence (p.16)

Little point in talking (p.8)

- Talking doesn't help Too unwell, (p.8)
- Unreachable (p.9 & 11)
- Medication the only option (p.15)
- Waiting for medication to settle them (p.8)
- Medicate them (p.8)
- Talking if not too unwell (p.8)

Hearing Psychotic monologue

(p.8)

- Listening without reply (p.8)
- Agreeing reinforces delusions (p.13)
- Not denying or avoiding delusions (p.13)
- Balancing act (p.13)
- Dismissing delusions isn't helpful (p.13)
- Fearing making them more unwell (p.13)
- Un-comfortableness of middle ground (p.13)

• Being unsure what to say	(p.13)
• Talking if not too unwell	(p.15)
• Eagerness to discuss worries	(p. 17)
<u>No formal training</u>	(p.7)
• Learning from mistakes and successes	(p.7)
<u>Assessing risk (p.8)</u>	
• Checking safety and hydration	(p.8)
• Being concerned for nurses safety	(p.17)
<u>Shutting them away</u>	
• Troublesome patients	(p.4)
• Staff quickly advocating seclusion	(p.3)
• Getting them out of the way	(p. 4)
• Punishing rule breakers	(p. 10)
• Violence, restraint, medication, seclusion.	(p.10)
• Shutting the door on dialogue	(p.3)
• Cannot reassure fears	(p.3)
<u>Shutting the door on dialogue</u>	(p. 3)
• Using worries to annoy them	(p.9)
• Aggravating situations	(p.8)
• Deliberately annoying patients	(p.9)
• Provoking violence	(p.9)
<u>Burned out and frustrated</u>	(p.10)
• Confined to older staff	(p.10)
• Nasty nurses	(p.8)
• Having a sense of resignation	(p.9)
• That's just the way they are	(p.9)
• Not confronting peers	(p.9)
• Bad practices fading out	(p.9)
• Better training currently	(p.10)
<u>Junior staff voicing opinions</u>	(p.6)
• Voicing different opinions	(p.6)
• Challenging senior staff	(p.6)
• Being listened too	(p.6)
• Trained to voice opinions	(p.5)
• Showing curiosity and assertiveness	(p.5)

Balancing the old and new

(p.5)

- good nurses are confident

(p.10)

New rules, poor practice

- Less time with psychosis

Keeping the party line

(p.2) (socialising)

- You are lying
- Discounting the 'other'.
- Dismissing nurses out of hand
- managing violent patients
- recounting amusing and violent stories
- Poor modelling

(p.2)

(p.2)

(p.2)

(p.10)

(p.10)

(p.7)

Becoming a dissident

(p.7)

Appendix E (2): Raising Codes to Higher Conceptual Levels

Interview 5 Service user 3

Not Living Up To Expectations

- Feeling disappointed with first nurse (p 29)
- Poor quality of conversations (p 5 & 6)
- Advocating nurses try harder to talk (p22)
- Picking up indifference and disbelief (p 6)
- Just going through the motions (p 6)
- Not addressing issues (p 6)
- Only interested in assessing effectiveness of medication (p 29)
- Showing more interested in diagnosis than him (p 6)
- Being confused about what was wrong (p 26)
- Wanting dialogue with first nurse (p 29)
- Avoiding talking about worries by changing medication (p 8)

Losing Opportunities

(p 29 & 30)

- Needing someone to listen and help (p 28)
- Getting more monologue than dialogue (p 6)
- Expecting more time to talk (p 6)
- Stopping dialogue feeling rejected (p 28)
- Take the meds and I'll see you in a month (p 29)
- Seeking counseling (p5 & 6)
- Advocating CBT (p 5)
- Being referred but never met counselor (p 9)
- Despairing about recovery (p 26)
- Regretting he wasn't honest with psychiatrist (p 5)

Hospitalization Aiding Recovery

(p 20)

- Paranoia reducing during hospitalization (p 21)
- Being hospitalized helps (p 16)
- Being pleased with absence of paranoid worries (p 8 & 19)
- recounting admission (p 18)
- Initially disliking hospitalization (p 9)
- Regretting prolonged hospitalization (p 25)
- Feeling annoyed psychiatrist didn't admit him sooner (p 8)

This is the end of me

(p 18 & 18)

- Reluctantly hospitalized (p 14)
- Being given no choice (p 18)
- Feeling trapped (p 18)
- No choice but to submit (p 14)
- Being hospitalized twice (p 9)

Regretting Leaving Hospital Too Soon

(p 9)

- Seeking early discharge (p 9)
- Deciding to sign himself out (p 9 & 10)
- Wanting to get away (p 10)
- Asking different nurses about discharge (p 9)
- Being differed to doctor (p 9)
- Learning nurses lacked power of discharge (p 9, 10)
- Fearing being kept longer (p 11)
- Acknowledging freedom of choice (p 10)
- Admitting he wasn't open with doctors (p 9)

Being Watched

- Naming "Core Delusions" (p 7)
- Worrying that HSE employees knew of and disapproved of his behaviour (p7)
- Keeping an eye on people (p 7)
- Government agencies tracking people (p 7)
- There is 'them' and there is 'us' (p 7)
- They are watching us (p 7)
- HSE workers knowing everything (p 16)
- They are talking about you (p 7)
- Recounting stories to support his worries (p 17)
- Ambulance workers turning on their sirens to annoy him (p 7)
- Trying to drive him mad (p 8)
- Linking different incidences (p 8)
- Worrying about hospitals intentions (p 8)
- Recalling his father recounted similar worries (p 7)

Medication Disappointment

(p 4)

- Not changing sense of danger (p 4)
- Couldn't sit down, concentrate or sleep (p 4)
- Affecting short term memory (p 4)
- Gaining weight (p 4)
- Impacting on ability to work (p 4)
- Nervousness and panic attacks (p 27)
- Difficulty remembering aspects of admission (p 19)
- Feeling constantly restless (p 27)
- Believing some medications can cause paranoia (p 13)
- Detesting injections (p 27)

Making a Stand

(p 27)

- Fighting to get medication reduced (p 27)
- Standing by beliefs (p 27)
- Being told reducing medication means hospitalization (p 27)
- Remaining well on less medication (p 19)

Helpful Medication

(p 8)

- Feeling less tense (p 4)
- Stopping medication increases worries (p 11)
- Regretting stopping medication (p 11)

Confused About Medication

- Being unsure how medication works (p 16)
- Unsure why different medications was prescribed (p 4)
- Unsure of the difference between prescribed medication (p 4)

Renaming 'delusions'

- The way they are thinking (p 25)
- Firmly fixed ideas (p 25)
- Oscillating worries (p 14)
- Moving between fixed and oscillating worries (p 14)
- elation and paranoia (p 14)
- Happy to be part of a system (p 14)
- Being tested for an important job (p 14)

Fearing Aggression from Nurses (p 18)

- Remembering nurse looking serious and expecting aggression (p 18)
- Nurse ready for action (p 19)
- Feeling afraid (p 18)
- Aggression creates aggression (p 18)
- Placing importance on non-verbal cues (p 18)

Initially Reluctant to Talk (p 7)

- Suspecting nurses motives (p 8)
- Thinking nurses were good actors (p 8)
- Being tested and observed by staff (p 10)
- Trying to discover most hurtful things to do to him (p 11)
- Incorporating professional non-verbal cues into fears (p 18)
- Including psychiatrist into conspiracy (p 5)
- patients are not really patients (p 14)
- Unsure of observers intentions (p 14)
- Not trusting doctors responses (p 18)

Revelling worries of being labelled mad or Dismissed (15)

Attempting to catch them out (p 8)

- Begun testing his worries about hospital (p 8)
- I'm sure you know all about me (p 17)

Risk Taking

- Nothing to lose deciding to share worries (p 14, 16 & 18)
- Hoping to stop or lessen torture (p 14)

Experiencing an Epiphany

- Realizing his fears were not going to happen (17 & 8)
- Turning point (p 25)
- Realizing nurses weren't talking about him (p 8)
- Changing his mind about peoples intentions (p 14)
- Becoming less paranoid (p 16)

Talking and Reflecting on Worries helped

(Externalizing Internal Dialogue)

- Talking with other patients reduced worries (p 14)
- Testing worries makes them disappear (p 15)
- Spending time with possible torturers (p 17)
- Confronting his greatest fears (p 17)
- talking makes a difference (p 15)
- Providing contrasts/differences provokes reflection (p 16)
- Knocking down one worry, knocks them all down (p 16)
- Domino effect on remaining worries (p 17 & 22)
- Began looking at events from different perspectives (p 19)
- Critically reflecting on worries through conversations (p 17)
- judging people on their reactions (p 17)
- Building trust (p 17)
- Worries stopped and haven't returned (p 8)
- unsure of transferability of what helped him (p 25)
- Hearing stories of professionals reducing clients worries by interacting with them (p 21)

Living Behind Enemy Lines

- Unfriendly forces out there (p 4)
- Ebb and flow of worries (p 4)
- Terrified about being caught and tortured (12, 13)
- Being vigilant about people's actions (16, 8)
- Something hidden from him (p 16)
- Hearing scary voices (p 12)
- Avoiding work as he might be tortured there (p 12)
- Being categorized as a 'bad person' (p 17)
- Bad things happen to bad people (p 12)
- Believing T.V. Programs referred to him (p 12 & 5)
- Deserving punishment (p 17)
- Keeping worries secret (p 16)
- Fear of imminent attack (p 12)
- Believing he was going to be killed (p 13)
- Cannot trust anyone (p 5, 16)
- Expecting him to creak under pressure (p 11)
- worrying his parents were imposter's (p 13)
- Acting appropriately if worries were true (p 11)

In the Horns of a Dilemma

- Acting appropriately if worries were true (p 11)
- Uncertain if parents were imposter's (p 11)
- Believing they were about to be killed (p 13)
- Like a horror film (p 13)
- in a delimia about telling his parents (p 13)
- Risk Taking and sharing worries with parents (p 12 & 13)
- Being brought to hospital (p 13)
- Confused about what was wrong (p 26)

Learning silence

- Getting funny looks (p 11)
- Caring about peoples reactions (p 11)
- Being made fun of (p 15)
- Risking negative reactions (p 15)
- To frightened to share worries (p 12)
- Becoming silent when disbelieved (p 11)
- Talking causes problems (p 11)
- Risking negative reactions (p 15)
- Silence is golden (p 11)

Internal Dialogue Only Please

- Too dangerous to reveal worries (p 11)
- Hearing similar stories where people were attacked (p 11)
- Believing he was beyond help (p 13)
- Experiencing serious increase in worries (p 12)
- Internal dialogue getting more extreme (p 16, 21)
- Retreating further within after negative reactions (p 21)

Bad things do happen

- Awareness that bad things happen (p 15, 11)

Righteous Anger

- Feeling angry when advantage is taken of people with mental illness (p 15)
- Justifying his stance (p 2)

Storm in the Head

(p 1)

- Constantly thinking about annoyances (p 1)
- Obsessing about hurts (p 1)
- Feeling Intensely got at (p 1)
- Very annoyed and wound up (p 1)
- Feeling persecuted (p 1)
- Being treated unfairly (p 1)
- Feeling alone (p 5)
- Confused about what was wrong (p 26)

Alone and Beyond Help

- Feeling alone (p 5)
- People are untrustworthy (p 5, 7)
- Devious and sneaky (p 5)
- Hidden agenda's (p 5)
- Too dangerous and frightened to share worries (p 11, 12)
- Believing he was beyond help (p 13)
- Too dangerous to attend work (p 12)
- Persecutors are lawless (p 12)
- Harassed and isolated (p 2)
- Being verbally aggressive with persecutors (p 16)
- Relying on past negative experiences as a guide (p 5)

Suffering Social Defeats

(P 3)

- Triggering factors (p 3)
- Being shunned at work (p 3)
- Experiencing harassment and isolation (p 2)
- Exclusion (p 3)
- Experiencing negativity at home and work (p 5)
- No let up (p 5)
- Feeling bad about himself (p 3)
- Traumatic social experiences (p 3)
- Relying on work for self-worth (p 3)
- Inability to confront tormentors (p 3)
- Remaining in negative work environment (p 4)
- Blaming himself (p 3)

Difficulties at work triggered it

(p 7)

- Believing work colleagues invented stories to upset him (p 15)
- Realizing he could not do his job well (p 4)
- Poor concentration (p 4)

Reaching a Crisis Point

(p 3)

- Expanding community of tormentors (p 3)
- Increasing sense of danger (p 13)
- Whole country was talking about him (p 8)
- Suffering social defeats (p 3)
- Ongoing storm in the head (p 1)
- Alone and beyond help (5, 13)
- Only engaging in internal dialogue
- Living behind enemy lines
- Despairing about recovery (p 26)
- This is the end of me (p 18)
- Wanting it to stop (p 8)

Nurses Reducing Opportunity to Help

(p 21)

- Negative reactions were unhelpful (p 21)
- Feeling Dismissed (p 21)
- Retreating further within after negative reactions (p 21)
- Disappointed by nurses reactions when feeling unsafe (p 23, 23)
- Risking relapse by inadequate responses to being assaulted in hospital (p 23)
- Avoiding asking questions about delusions (p 25)
- Receiving vague general responses (p 25)
- Talking to the illness not the person (p 25)
- Awareness nurses are advised not to argue with a delusion (p 25)
- Didn't say much to nurses (p 9)
- Rejection stops dialogue (p 28)

Uncertainty around nurses motivates

(p 20)

- Initially judging them ignorant or bad (p 20)
- Disbelieving reassurances (p 20)
- Very sensitive to others reactions (p 21)

Preparing the ground for recovery

- Valuing reassurance about safety (p 22)
- Receiving positive feedback (p 22)
- Showing interest in what he said (p 22)
- Listening actively (p 22, 28)
- Showing readiness to listen (p 26)
- Keeping conversations general (p 24)
- Is there anything you want? (p 24)
- Is there anything on your mind? (p 24)

- Arriving with an introduction (p 19)
- Feeling more relaxed after shown kindness (p 19)
- Impressed by nurses calmness (p 21)
- Encouraged to talk by positive reactions (p 21)
- Sharing worries encouraged by listening and non-judgmental (p 28)
- Encouraging talk (p 28)

Sowing the seeds

- Needing to check the meanings of what people say (p 21)
- Advocating obtaining a personal history from family and friends (p 24)
- Needing to know the person and worries really well (24, 24)
- Know my story (p 24)
- Placing importance on receiving explanations about symptoms (p 25)
- Instilling hope and time frames (p 25)
- Increasing trust in what nurses say (p 21)
- Placing importance on how and what professional talk (p 26)
 - Awareness nurses worry talking might thing worse (p 24)

Reaching a crisis deciding to talk

- Crisis provoking change (p 16)
- Receiving alternative explanations to worries from people most feared (p 26)
- Never heard an alternative explanation before (p 26)
- Listening to different perspectives (p 28)

Harvesting meaningful dialogue

- Treating worries seriously (p 25)
- Showing respect, responding honestly (p 29)
- Believing alternative explanations (p 26)
- Being instrumental in changing beliefs (p 28)
- Maybe there is something in it (p 29)
- Respectful discourse (p 28)

Unsure if conversations with nurses contributed to recovery (p 29)

Visiting at home

(p 27)

- Community nurse visiting (p 27)
- Asking brief questions (p 28)
- Showing concern (p 28)
- Checking for psychosis (p 28)

Getting Back to Work

- Joining supported work schemes (p 27)
- Difficulty working on high doses of medication (p 27)
- Experiencing side-effects (p 27)

Difficulties Remembering

- Difficulty remembering talking to nurses (p 20)
- Remembers some nurses (p 20)

Sharing worries with strangers could set him back

(21)

Taking on Blame

- Blaming himself for relapse (p 10)
- Smoking too much cannabis (p 10)
- Returning to work too soon (p 10, 11)
- Throwing petrol on a fire (p 10)
- Regretting stopping medication (p 11)
- Not a great patient (p 27)
- Believing not following advice increases risk of relapse (p 27)

Appendix F (1)

Memo 6/9/2010

Tentative Core Category: finding permissible voice

Trying to identify the main category has been exciting and frustrating as it has to encompass both nurses and service users. I found that initially I was focusing more on the service user rather than nurses and as a result initial ideas main concern and core category did not 'fit' for all participants. At present, the main concern is being conceptualised as, *'Constraining permissible contact: struggling to walk the line of allowed talk'* where all participants were constrained by institutional, cultural practices and beliefs regarding what they can and cannot discuss.

Hence, the core category centres on the concept of, permissibility, and how participants resolve/manage these restrictions, which play out in each nurse-client interaction. In that, the two parties in their own way were concerned about what was and was not permissible to say and do, and the possible consequences if they veered into what had been defined as non-permissible. In that, certain ways of talking, interacting and topics were discouraged both explicitly and implicitly, as participants worried that something catastrophic might occur, such as, experiencing ostracification from ones community, given extra-medication or being responsible for a client becoming more psychotic. At the moment, I am conceptualising the core category as, *negotiating permissible and non-permissible contact: nurse-people in psychosis interactions*. This negotiation involves the sub-core categories; *Re-defining permissibility: Finding Voice* and *validating permissible talk: Sharing voice*.

The negotiation of what constituted permissible and non-permissible contact occurred when participants' navigated a different way of talking about issues of concern; a broadening of the 'narrow line' that institutional and societal custom and practice maintained. This was possible when nurses and clients felt too constrained by accepted ways of talking and interacting, between nurses and people in psychosis, began to test these boundaries.

Finding Voice here participants either adhered to the prevailing restrictions or move beyond them to varying degrees. Within the nurse-client in psychosis interactions, participants sought to ease dis-ease, and offered help, more importantly it comprised of human interactions. Through this interaction the re-defining of what was permissible to talk about happened, by weighing risk of not walking the line and seeing the possible benefits of widening the traditional definition. It is interesting that while nursing participants talking about adhering to traditional type of conversations in practice they very often move beyond these restrictions in response to: requests from clients; trying to ease client's distress or positive past interactional experience. However, these conversations never got shared with other nurses due to perceived negative or disinterested reactions. They were a type of 'shadow' conversations. *Validating permissible talk: Sharing voice*, is where by participants sense of personhood is validated by sharing 'stories' both person and professional. This

facilitated a creation of understandings and meaningful connections between participants, where participants were able to have more open conversations occurred.

Appendix F (2)

Memo 23/5/2011

Tentative Main Concern and Core Category: Achieving Permissible Contact

In the initial phase of the study, participants' were invite to talk freely about their views on understandings of the nurse-patient communications, psychosis and their ideas on what if anything could be different to enhance communications between them. Analysing the data through identifying initial categories and their properties sets up relationships with the data and between the categories themselves. The categories were raised to conceptual level, with the aim of the study at this point was to identify the participants' main concern. The main concern of participants' that emerged centred on, '*achieving permissible contact*' where participants struggled find a balance to how they interacted; in particular attaining a sense of what was permissible and not permissible interactions between them. They were pre-occupied with finding ways they could communicate with each other that either participant thought might be helpful, and which to avoid or minimise any potential negative consequences. They attempted to do this by adhering to personal, institutional, cultural and practices and beliefs regarding what they could and could not discuss with each other.

Participants either implicitly or explicitly bought into institutional and cultural rules regarding permissible and non-permissible talk that restricts opportunities to openly converse about issues of concern, which resulted in an invalidation (to varying degrees) of their sense their of personhood. Here, certain topics or ways of talking were not given 'voice', as they were deemed by institutional practices and/or societal beliefs that it was either not useful or potentially damaging to do so. Overall, both nurses' and service users' generally struggled to keep to this narrow path of what was permissible and not permissible to say and do, as they found that in the interplay of the nurse-service user interactions constrained conversations to issues just pertaining to illness. Such as, reporting of symptoms, explanations and languaging of experiences from a bio-medical perspective. Thereby, diminishing their capacity and opportunities to interact on a more human level, in that, by adhering to established interactional practices solely, it devalued or silenced certain other 'voices' and ways of talking.

In grounded theory how participants process and resolve their main concern is where the 'theory' is developed. However, the author contends that one needs to understand the context and psychosocial processes involved in how this invalidation is constructed and enacted, as understanding is only possible when one is seen in relation to the other (Bateson 1972). The construction of how certain voices or narratives become diminished or silenced, between nurses and service users' is interesting considering that talking to service users is acknowledged as a significant part of nursing care, and the amount of time they devote to it is a good indicator to the quality of care.

One possible consequence from a nurses' perspective which dominated their inner and outer dialogue centred on a fear of, 'digging too deep' when in conversation with service users. Here, nurses worried that what they considered delusion and hallucination would become stronger if attend too in conversation. In fact, some nurses considered engaging in dialogue about their hallucinations/delusions unethical, as the service users might become more even

more unwell. Also, with reference to fearing dire consequences, quite a number of nursing participants had an expectation, constructed through ward socialisation, of an overall unpredictability and a heightened sense of dangerousness, when engaging with people in acute psychosis. This expectation resulted in many nurses appearing to service users as tentative and reserved in their interactions, hence in-depth engagement was generally avoided, especially in the early period of the service users' admission. In the absence of a way forward, or role model, regarding talking in-depth with service users, these types of interactions tended to be catastrophised. As a consequence, focus shifted more to 'symptom spotting'; observing and enquiring for signs and symptoms of psychosis. Adhering to 'walking the line', other ways of interacting with service users were invalidated; interactions and types of conversations nurses employed with other patients that had a non-psychotic diagnosis.

The above occurred in the context of intuitively practices that was played out through worries and fears, which shaped nurses' interactions. Veering from 'walking the line' engendered apprehension in nurses as they did not feel either safe enough or skilled enough to re-define what was permissible. Difficulties and tension points arose when service users either requested to talk or showed distress, on these occasions the limits around permissible talk became blurred, as some clients wanted to talk about issues of concern that fell outside the institutional custom and practice parameters. Here, nurses wanted to help them, not only to ease their dis-ease, but also ease the nurses own apprehensions

In relation to nurses, they seek to help service users in psychosis by silencing the voices of illness, in particular, what they classify as 'hallucinations or delusions'. This help was often initiated in the context of the service user appearing distressed or disabled by these experiences. Generally, nurses attempted to help by ensuring medication compliance, providing a safe environment and offering 'reassurance' when needed. The silencing or putting aside non-permissible interactions and ways of talking was considered as necessary until medication diminished the voice of illness; service users displayed less symptoms.

Service users also sought help for distressing worries and fears, as some of these voices were quite demeaning and derogatory. However, it transpired that in the process of adhering to what was permissible to say and do, sometimes participants felt that either they were not listened too, and/or they could not help the distress. As service users experiencing acute psychosis were regarded by nurses as having a serious mental illness that impaired their capacity to make informed decisions, due to experiencing 'fixed false beliefs'. Hence, all service users' beliefs and opinions could be considered suspect; carried little validly. Also, some nurses' voices and possible ways of interaction were diminished, in that, they wondered was there some meaning or relevance in what the service users are saying and that it could be useful to engage with them in a more meaningful way. However, in the context of a professional dominant story that says, 'service users are too ill to engage in meaningful conversations, these types of conversations can only happen once medication begins to work'. These potential ways of talking were generally either not acted on, or openly spoken about to peers; a form of shadow conversation.

Service users also feared dire consequences' especially if they spoke openly about their worries. In particular, when they shared their fears and worries with friends, family and work colleagues, they experienced invalidation by being encouraged to keep those worries and beliefs secret. This occurred in a number of ways, such as: being made fun of; feeling dismissed; being advised to stay silent; causing of worry and fear within their social realm; or

being aware of the above possible consequences. Therefore, a sense of 'Learned permissible talk' was constructed, which some service users saw as confirming their fear of stigmatisation; of being ostracised from their community. Also, they were quite concerned about being: 'fixed in time' - if a lifelong diagnosis was acquired; 'labelled as an illness', thereby losing personhood. They were also aware of having a sense of or a 'stamp of dangerousness' and considered as unpredictable, which had been put on them by various media outlets and by their community at large.

Not only do service users learn to become silent due to reactions from friends and how some aspects of the media portrays psychosis, but also some of their inner dialogue can centre around fears and worried of being 'killed or assaulted'. In that, they are being talked about (slandered), plotted against, and that they and /or their families are about to be harmed. Another aspect of the clients, fearing dire consequences if they talk openly, relates to when they are hospitalised, and the realisation that while there if they gave voice to certain worries and behave in a certain way it could 'prolong hospitalisation'. They also recognised that nurses are keen to find out if some of the content of their inner dialogue is changing (diminishing or not), and that the giving of this information can influence not only the amount and type of medication prescribed, but the length of hospitalisation itself.

As already indicated, a primary concern of nurses' was to help reduce service users' distress. In order to achieve this within the bounds of what was deemed permissible, nurses tended to focus on two main approaches, these were, keeping the service user calm (by trying to avoid any emotional excesses), and ensuring medication compliance. They attempted to achieve this by trying to achieve a balance between, maintaining most conversation at a superficial level, what nurses call, 'keeping conversations light', but also by not totally ignoring them. Some nurses describe it as, 'walking a tight rope', in that, they try to just say enough that the service user feels reassured and safe, and to build up a rapport so that when they are 'well enough' they will talk to the nurse in a more meaningful way. However, people in psychosis sometimes viewed the above as: avoidance of talking with them about their difficulties/worries; feeling dismissed; disrespected; and just being treated as an illness. For participants' these patterns occurred in the context of an overarching fear that something terrible might happen if they engaged in an open and meaningful way.

Appendix F (3)

Memo 5/1/2014

Tentative Core Category: Guarded Openness

The core category that emerged was conceptualised as *Guarded Openness*, which describes how nurses and clients manage to communicate with each other, within the context of being service users and employees of mental health services.

It describes a process that allows nurses and clients to communicate somewhat safely; by developing safeguards as they strive to understand what is safe to say and do within each communicative episode. This process is dynamic in the sense nurses and clients are uncertain about how guarded or open they should, or need, to be with each other. This uncertainty creates a tension both internally and in the space between them. Hence, they have to manage these tensions while trying to figure out how open or guarded he/she needs to be. To facilitate this figuring out, nurses and clients attend too what they believe constitutes risky communication and what constitutes possible safe or helpful communications. Once an understanding of what is permissible is reached, it does not stay fixed, as it is liable to change if either the client's or nurse's sense of risk increases, or if one or the other deem that it could be advantageous by being more open. Hence, the level of *guarded openness* can quickly change in response to either party's increased or decreased sense of risk, security or wish to access and deliver help for felt unease. Thus, guarded openness is always present within their communications.

The process of nurses and clients establishing what each consider appropriate *guarded openness* is partially implicit, in the sense, that there are generally no explicit negotiations or open agreements about what are understood as permissible communications, yet understandings are reached. These understandings are based on what they believe is permissible at that moment in time, which are worked out both in own their inner conversations and what is happening in the space between them. This is an interactional space where the nurse and client can recursively influence the degree of openness or closeness within their joint communications. The process is also influenced by: past interactional experiences between different clients or nurses; socialised wariness regarding talking openly about the psychotic experience; both professional and personal custom and practices; along with what either consider helpful to say and do at that moment in time. Hence, to varying degrees, nurses and clients are active participants in the assembly of their understanding of communicative *guarded openness*.

However, no matter where they place themselves within *guarded openness* they face dilemmas when they are either contemplating or actively communicating with each other. One of these dilemmas centres around whether to try and stay safe by becoming guarded about what they say, or becoming more communicatively open to with the hope of that it might aid the receiving of, and giving help for felt unease. Hence, *guarded openness* provides a way to resolve or manage their predicaments by giving them time and space when trying to figure it out.

Overall, *Guarded Openness* describes a dynamic process that allows nurses and clients to communicate somewhat safely, which not only facilitates the establishment of what are permissible communications, but has the flexibility to permit the altering of their

understanding of permissibility if needs be. Hence, nurses and clients can fluctuate between being highly on guard, to somewhat letting their guard down. This process is portrayed in the two sub-core categories, *closing guardedness* and *opening guardedness*. Figure 1 is a diagrammatic representation of the theory. This theory highlights the complex nature of how nurses and clients come to understand what is permissible to say and do while communicating with each other.

Figure 1. Core Category, Sub-Core Categories and Categories

Guarded Openness						Core Category
Closing Guardedness			Opening Guardedness			Sub-Core Categories
Socialised Inter-actionable Wariness	judging Communicative Risk	Keeping Conversations Light	Seeking Helpful Communications	Developing Safety	Addressing Issues of Concern	Categories

The first part of *guarded openness* is *closing guardedness*. Initially, due to a process of socialisation, nurses and clients learn to be somewhat guarded about being too open with each other, in particular about the psychotic experience. Nurses learn from colleagues to try and avoid or minimise communications with clients, as holding open conversations is not considered useful in resolving psychosis. These learned apprehensions introduce a heightened sense of risk, which for nurses intensifies when they also believe that, engaging in certain sorts of conversations with clients could result in making their illness more severe, or trigger an aggressive episode. Thus, being communicatively guarded when interacting with clients, is an approach that nurses' advocate in order to try to and make these communications safer. Clients learn that if they speak openly about their psychotic experiences with family, friends and those who live within their communities, they were likely to be ostracised; to varying degrees. Thus, they found it useful to become guarded about what they revealed to others; it provided them with some protection. Therefore, on one hand, this guardedness introduces a sense of interactional riskiness for the nurse and client, where one or both appeared cautious and tense within the initial stages of their communicative episode. On the other hand, it is also a protective process, as they are initially uncertain what will happen in each interaction, hence, it is judged prudent to be somewhat guarded until they figure out what is happening within a particular communication.

Their sense of guardedness intensifies when they identify specific communicative risks. One possible hazard for most nurses' is being uncertain of the validity of clients' opinions and beliefs, as there is a view that people experiencing acute psychosis are too ill to hold rational conversations. This risk is managed by being generally suspicious of what clients' says to them. Disbelieving clients' opinions also gives nurses a rationale to make certain decisions on a client's behalf, for example, ensuring compliance with the taking of anti-psychotic

medication, even if the client disagrees. Clients also become suspicious when they identify possible risks to themselves. One threat, for some, is being informed that their worries and experiences are a product of a mental illness and need to take medication, and/or stay in hospital, which they reject. Hence, they become suspicious of nurses' motives as they believe that they were not ill, their worries are real, thus, are being unjustifiably confined and/or prescribed strong medication that causes unpleasant side-effect. Therefore, being suspicious aids nurses and clients to identify, and begin to manage these perceived risks. Another risk that both are keen to identify is any threat to them or others regarding hostility and aggression. When nurses and clients identify these possible risks they quickly become quite guarded about what they say to each other in case it puts them in a more vulnerable position.

However, despite worries about communicating together, nurses and clients have to and sometimes need to communicate together. The *having too*, usually relates to practical issues, such as, enquiring about being discharged or encouraging medication compliance. The *needing to*, usually refers to seeking help for felt unease or giving help for felt distress. On these occasions they try to manage to balance their felt heightened risk and having to communicate by the offering and receiving general re-assurances for worries and distress that a client is experiencing. The intent from a nursing perspective is to temporally reduce clients' worries and felt distress without causing problems. This approach is employed until it is judged that medication has begun to resolve the psychotic experience. Similarly, clients seek and accept re-assurances, that will somewhat ease their distress, while at the same time being careful not to reveal too much of their inner conversations. Another approach is where clients and nurses attempt to reduce upset, distress and sometimes aggression, by saying what they thought the other wanted to hear. Some clients try to gain an early discharge (if hospitalised), a reduction in medication, or more leave home by pretending to be well. Nurses often attempt to reduce distress or aggression by telling the client that their hospitalisation will be brief, make promises of recovery if they adhere to treatment plans, or give guarantees regarding their future availability to help him/her. This approach sometimes results in nurses and service users engaging in a reciprocal interaction where one is trying to hide their symptoms, while the other attempts to uncover them, within the context of *closing guardedness*.

The second part of *Guarded Openness* is *opening guardedness*. This refers to a process where nurses and clients become somewhat less guarded because at times permissible communications associated with *heightening guardedness* did not seem to be enough to ease clients' unease. As a consequence, they begin to tentatively lower their guardedness to different understandings of what is permissible to say and do. This process of *opening guardedness* is usually initiated in a number of ways. It can be instigated by those clients who are experiencing an unsustainable burden regarding their worries, and reach a crisis point, where they can contemplate suicide or believe that they are about to be killed. However, it usually is not a straight forward decision, as they often have to choose between what they consider different possible harmful consequences. Such as, being convinced that they are constantly under serious threat which has become unsustainable, and revealing their worries that potentially might either ease or increase their burden. Hence, for some they are prepared to be somewhat more open in the hope it will ease their difficulties. *Opening Guardedness* can also happen when a nurse who has previous experiences of more open forms of communications with clients, introduces this openness into their interactions. However, they also experiences apprehensions and tensions about these decisions, as there is uncertainty about its outcome. Once openness is introduced, the nurse/client has a choice to respond in a similar fashion to the others invitation to talk. If they indicate that they wish to proceed, they

then begin to make the communication episode safe enough, where issues of concern can be addressed.

Clients sometimes try and ensure the likelihood that their issues will be heard and the communication will be safe is by, choosing which nurse to talk to. This is achieved by observing how different nurses interact with other patients, and/or their own past interactional experience with certain nurses. They seek someone who will engage with them in a respectful and meaningful way. A similar pattern occurs when a nurse is deciding whether to engage somewhat more openly with a client. They note if he/she shows some willingness to discuss their upset/issues, the absence of aggression, and sometimes relied on past positive open communicative experiences. In other words, both employ a process of attempting to ensure that the communications will be safe.

Initially when clients or nurses seek to communicate somewhat more openly, the other usually responds from a position of guardedness. However, if they attend to the above indicators, tentative steps are taken to open their guard about what is permissible to discuss. However, in order to proceed both have to contribute to a communicative sense of safety and trust. The development of feeling safe enough, is also facilitated by both giving each other dedicated time and space. The giving of, and spending time, is generally considered a powerful symbolic statement, as it infers that the other considers them important enough to spend time with, rather than someone or something else. Hence, the process of giving and spending time helps to develop what some participants called a human connection, which contributes to their sense of well being. This process has a recursive dimension, as giving and accepting time and space with each other further enhances their sense of communicative safety.

When they feel safe enough, some begin to explore how to listen and respond to each other in a way that allows the telling of, and attending to, those relevant issues that each deems important. These issues are usually about: clients' worries; problem solving regarding life events; the psychotic experience; various treatment plans for psychosis; ward routine; and recovery. However, within this process of *opening guardedness* attention is continually paid to the other's verbal and nonverbal communications, which allows for flexibility regarding what is permissible to say and do, if either decides it has become unsafe.