



‘Like a human being, I was an equal, I wasn’t just a patient’: Service users’ perspectives on their experiences of relationships with staff in mental health services

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Objectives. The quality of therapeutic relationships in psychiatric services has a significant impact upon the therapeutic outcomes for people diagnosed with a severe mental illness. As previous work has not explicitly explored service users’ in-depth views about the emotional impact of these relationships, the objective of this work was to bring this perspective to the fore and to gain a greater understanding about which relational components can lead to psychological change.

Design. The project was conducted alongside a service user organization. An interview design was used to qualitatively explore service users’ experiences and perceptions of their relationships with mental health practitioners.

Methods. Eight individuals who had experience of the mental health system in the United Kingdom were interviewed. Interpretative phenomenological analysis was used to analyse the data.

Findings. Three superordinate themes emerged from the analysis. These were (1) *Trying to survive: am I a person or just an object in the system?*; (2) *Traumatic experiences within relationships*; and (3) *Helpful and transformative relationships*. Further, the key transformative components of these relationships were *power, safety, and identity*.

Conclusions. Mental health services should be more focused upon *care*, rather than *control*. The Power Safety Identity (PSI) model, a reflexive model based upon key relational components highlighted by participants, is proposed for services and professionals to consider their work. The components of this model are managed by mental health practitioners and can determine whether these relationships maintain, increase, or alleviate psychological distress.

Practitioner points

- Awareness of the relational components of *power, safety, and identity* has the potential to help practitioners reflect upon the tensions they experience in their relationships with service users.

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- Mental health services and professionals that are sensitive to issues related to *power, safety, and identity* when responding to the needs of the service users can improve how individuals perceive the quality of care provided by them.
- Relationships between service users and mental health practitioners can encourage recovery if they are consistent, safe, trusting, provide protective power, and mirror a positive sense of self.

The medicalization of psychological distress has been historically rooted within psychiatry and psychology-based mental health systems. There continues to be a long-standing debate regarding the links between the medicalization of emotional distress, psychiatry, and social control (e.g., Bracken *et al.*, 2012; Foucault, 1967; Ingleby, 1981; Laing, 1967; Moncrieff, 2008; Rose, 1985; Scheff, 1966; Szasz, 1974). This can be further contrasted within the development of the humanistic psychology movement that has, from its onset, adopted a more holistic, growth-orientated perspective of psychological distress (Bugental, 1964; Hanley & Winter, 2016). As a consequence of these challenges, compulsory admissions have risen dramatically over the last 30 years in the United Kingdom (Health and Social Care Information Centre, 2013), with up to 20,000 people being unwillingly detained at a single point in time (Kinderman, 2014).

The United Nations recently noted, 'Coercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help with mainstream mental health services' (United Nations, 2017, p. 15). Despite the best intentions of supportive individual mental health professionals, in practice, the threat of coercion can therefore overshadow service users' experiences within the mental health system and lead to them hiding their true feelings and needs (Rogers, 1993). These experiences are reported as widespread in inpatient settings and have a significant impact on individuals' trust of mental health professionals (e.g., Frueh *et al.*, 2005; Johnstone, 1999; Lu, Mueser, Rosenberg, Yanos, & Mahmoud, 2017). In response, changes have occurred that aim to address the need for alternatives to the dominant medicalized approach to psychological distress (e.g., Division of Clinical Psychology, 2013; Johnstone & Boyle, 2018).

Many critiques of psychiatric research note that service users have historically had little opportunity to express their opinions about their experiences of mental health care (Bracken & Thomas, 2001; Shepherd, Boardman, & Slade, 2008). In the 1980s, a service user movement began to emerge (Campbell, 2009) and since then it has gained momentum as a collective international political force. The movement is now global, with organizations advising national governments, the World Health Organization, the United Nations and the World Psychiatric Association (Wallcraft, Rose, Reid, & Sweeney, 2003). This service user-led approach to mental health care is concerned with human rights and dignity, and advocates a move away from a biomedical model of mental distress towards a more interpersonal and humanistic approach to mental health care.

The therapeutic relationship in psychiatric services

Previous research has shown that the quality of therapeutic relationships in psychiatric services has a significant impact upon outcomes for people diagnosed with severe mental illness (Johansson & Eklund, 2003; McCabe & Priebe, 2004; Priebe, Watts, Chase, & Matanov, 2005). Such findings are unsurprising, as it is widely accepted within psychology and psychotherapy that being in caring relationships with others is a basic human need for constructive growth (e.g., Stern, 2004). Further, the centrality of the therapeutic relationship is documented in seminal theoretical literature about; what

works in psychotherapy (Norcross & Wampold, 2011), attachment theory (Bowlby, 1951), humanistic psychology (Rogers, 1957, 1959), and theories of intersubjectivity (Levine & Friedman, 2000). All of these highly esteemed writers place the therapeutic relationship at the heart of psychological change. Within the context of the study reported here, it is notable that mental health service user experience-based studies have previously shown that relationships with mental health practitioners are decisive factors in either helping or hindering recovery from severe mental distress (Borg & Kristiansen, 2004; Denhov & Topor, 2012; Ljungberg, Denhov, & Topor, 2015, 2016; Schön, Denhov, & Topor, 2009; Ware, Tugenberg, & Dickey, 2004). This type of research has consistently shown how service users value shared power, trust, mutuality as humans, continuity, and feeling safe in their relationships with mental health staff.

Rationale

The aim of this research was to explore and enrich our understanding of how people who used mental health services experienced their relationships with practitioners, and how they perceived these relationships to impact on them. In doing so, it purposefully utilized the experience-based knowledge of service users to find out more about what can be effective when supporting people in mental distress. Although such service user-informed research is commonly recommended (e.g., Beresford, 2016; Denhov & Topor, 2012; Langharne, 2004; Newman, O'Reilly, Lee, & Kennedy, 2015), it remains sparse on the ground and is often marginalized and devalued in mental health research communities (Beresford, 2016; Langharne, 2004). In discussion with a partner service user group, and in acknowledgement of the importance of such work, the following research question was posed: *What are mental health service users' experiences and perceptions of helpful and unhelpful relationships with mental health practitioners?*

Method

Design

This project adopted an Interpretative Phenomenological Analysis (IPA) research design (Smith, Flowers, & Larkin, 2009). IPA is a systematic qualitative approach of research that is 'committed to the explanation of how people make sense of their major life experiences' (Smith *et al.*, 2009, p. 1). As such, IPA therefore proved fitting with the objective of the study.

The project was completed in collaboration with an independent service user-run mental health charity in the north of England. It was purposefully conducted outside of the freely available national health services so as to mitigate the power imbalances between professionals and service users (Beresford & Wallcroft, 1997; Lindow, 2001). The service was entirely run by volunteers with lived experience of mental health problems for the benefit of people who identified themselves as suffering from a mental health problem. Further, it is notable that the charity's management committee were involved in the research process from the beginning stages through to the end of the project.

The research team

In keeping with expectations for qualitative research, a brief statement about the research team is provided (Levitt *et al.*, 2018). The researchers in this project include experienced qualitative researchers and practising psychologists. The named authors have an interest

in issues related to social justice in therapy and the growing experts by experience movement. As noted above, a local service user-run charity supported these individuals in this project. We do not name the organization due to the ethical commitment that was agreed at the outset of the work; however, these individuals were instrumental in directing the project and supporting the named researchers understanding of the analysis.

Recruitment

A purposeful sampling strategy was adopted (Hanley, Jordan, & Wilks, 2015). Individuals were recruited into the study who self-reported as having problems with their mental health and, as a consequence, had experiences of relationships with practitioners in mental health services. Individuals were excluded from participation if they had recently accessed crisis care or they did not fully understand what participating in the research would involve, and were therefore unable to provide informed consent.

Participants

Eight service user participants were recruited for the study. This proves in keeping with other IPA studies, with between four and eight participants is a usual sample size in such work (Brocki & Wearden, 2006). Recruitment took place at three support groups based in community rooms used by the service user group. Each group had between 15 and 20 attendees. Fourteen people registered an interest in taking part in the research, with six people being excluded after follow-up conversations. Of the eight participants interviewed, four were male and four were female. The participants' age, ethnicity, types of practitioners seen, mental health services used, and self-reported diagnosis are shown in Table 1. All of the participants reported episodes of severe psychological distress and had been in relationships with mental health practitioners in secondary care, whilst seven also had experiences of using psychiatry services.

Data collection

All of the participants took part in a single in-depth interview. These interviews explored the participants' experiences of relationships with professionals in mental health services. The initial question asked was, 'Could you tell me about your experiences of working with mental health professionals?' The aim of this open-ended question was to give each participant the opportunity to interpret the question in a way that was meaningful for him or her. The length of the interviews varied from 45 to 90 min, and they were conducted at either the charity's offices or at a local university. All of the interviews were audio-recorded and transcribed in full by the first author. Anonymity has been provided for the participants, and all of the names used are pseudonyms.

Data analysis

The analysis was conducted by the first author and followed the stages advocated by Smith *et al.* (2009). This emphasizes the importance of analysing each single case in depth, with a focus upon understanding the unique lived experience of the participant. Analysis began with the transcribing of the audio recording and immersion into the single case. During this process, notes of initial reactions to the data were made. This was followed by a descriptive stage that involved mapping out the data onto a flip chart sized piece of paper.

Table 1. Participant demographics

Participant	Age range	Ethnicity	Practitioners worked with	MH services used	Self-reported diagnosis
Joan	30+	White British	Consultant psychiatrists, a counsellor, a social worker, mental health nurses, community psychiatric nurses (CPN), occupational therapist (OT), a care coordinator, support workers, and her general practitioner (GP)	Psychiatry services both inpatient and outpatient, mental health charities, primary care mental health, community mental health teams (CMHT)	She does not mention a formal diagnosis. She describes symptoms of depression and suicidal thoughts
Marcus	50+	White British	Psychiatrists, counsellors, psychologists, mental health nurses, CPNs, social workers, and his GP	Psychiatry services both inpatient and outpatient, primary care mental health, mental health charities, CMHT, and Accident and Emergency (A&E)	He describes experiencing psychosis, hearing voices, hallucinations, anxiety, suicidal ideation, and paranoia
Martha	60+	White British	Psychiatrists, a cognitive behavioural therapist (CBT), counsellors, support workers, OTs, mental health nurses, her GP, and a breast cancer surgeon	Psychiatry inpatient and outpatients, a council run occupational health service, primary care mental health, a social inclusion service, mental health charities, and a user-run group	Diagnosed with bipolar
Paul	60+	White British	Psychiatrists, mental health nurses, a counsellor, and social workers	Psychiatry inpatient, outpatient and specialist services, an old age mental health service, CMHT, crisis team, and his GP	He does not mention a formal diagnosis but talks about suffering with depression, anxiety, and suicidal thoughts
Ryan	20+	White British	CBT therapist, a psychotherapist, a mental health nurse, and a GP	Single point of access service, a primary mental health care service, and a user-run group	Diagnosed with generalized anxiety disorder, anorexia, and depression. He self-diagnosed avoidant personality disorder

Continued

Table 1. (Continued)

Participant	Age range	Ethnicity	Practitioners worked with	MH services used	Self-reported diagnosis
Rebecca	30+	White British	Psychiatrists, counsellors, CBT therapists, CPNs, an OT, mental health nurses, support workers, a psychotherapist, and her GP	Psychiatry service both inpatient and outpatient, an eating disorder unit, the crisis team, and a user-run group	Diagnosed with anorexia, post-traumatic stress disorder (PTSD), and personality disorder
Harley	30+	Black British	Psychiatrists, mental health nurses, CPNs, and GPs	Psychiatry outpatient services, user-run groups, A&E, and mental health charities	Diagnosis of schizophrenia and psychosis. He described experiencing depression, psychosis, and hallucinations
Fayah	30+	Asian British	Psychiatrists, mental health nurses, key workers, therapists, social workers, a CBT therapist, counsellors, an occupational therapist, and psychologists	Psychiatry inpatient and outpatient services, an eating disorder inpatient unit, intensive care, and counselling services	Diagnosed with an eating disorder

This process enabled parts of the text to be visually understood in relation to the whole text and vice versa. This was then repeated with the remaining interview recordings, with the aim of staying close to the participants' account of their experiences. The single case analysis led to the development of superordinate and subordinate themes illustrated using verbatim extracts. A cross case analysis of all eight cases was then conducted to identify superordinate themes and their own associated subordinate themes. At this stage, there was a shift towards a more interpretative approach which involved analysing the deeper contextual meanings within the text (Smith *et al.*, 2009).

Throughout the analytical process, participants were offered the opportunity to review the transcript of their interview and to review the quotes ultimately used in the write up of the work. Four people chose to review the quotes and requested no changes. In addition to this, reflexive activities played an important role in ensuring that the primary researcher remained attuned to her own understandings and responses to the interviews (Finlay, 2002). Reflective journals were kept throughout, and mind mapping exercises (Tattersall, Powell, Stroud, & Pringle, 2011) were engaged in so as to aid sensitization to the topic during analysis. The interpretative understandings of the interviews were then shared with the second author and members of the charity who supported the work. These coherence checks proved useful in ensuring the broader resonance of the findings (Elliott, Fischer, & Rennie, 1999).

Ethical considerations

The participants were considered to be from a potentially vulnerable group due to having experienced mental health difficulties. As such, ethical approval was obtained from the local NHS Research Ethics Committee.

Findings

Three superordinate themes emerged from the analysis. These were (1) *Trying to survive: am I a person or just an object in the system?*; (2) *Traumatic experiences within relationships*; and (3) *Helpful and transformative relationships*. Each superordinate theme came with constituent subordinate themes. These are presented in Table 2 and described further within this section. These descriptions include accounts from the participants and interpretative content that links directly to the model presented within the "Discussion" section of this paper. This model highlights the importance of the higher-order concepts of *power*, *safety*, and *identity* within the relationships that individuals have with mental health professionals in these settings.

Trying to survive: am I a person or just an object in the system?

The participants all spoke about their relationships with mental health practitioners within a narrative that began with their personal experiences of mental distress and their search for help from mental health services.

The internal battle with mental distress. The participants' commonly described their 'battle' with mental distress to be the reason for needing help from mental health staff. Rebecca, Fayah, and Ryan described seeking help in response to having a 'breakdown',

Table 2. Superordinate and subordinate themes with illustrative extracts

Superordinate themes	Subordinate themes	Supporting extracts
1. Trying to survive: am I a person or just an object in the system?	1a: Internal battle with mental distress	I was on a train going towards death... I couldn't get off
	1b: Help-seeking	Help me out, I need your help
	1c: The mental health system experienced as disempowering and dehumanizing	And no one explained to me... that was a big issue with control
2. Traumatic experiences within relationships	2a: The unknown practitioner	You need to know the person you're talking to is going to help
	2b: The relationships that diminish self-worth	He made me feel small, he made me feel frightened
	2c: Given treatments that didn't work	It wasted so many years
	2d: The patients' defensive reaction	I just shut down
3. Helpful and transformative relationships	3a: Being treated as a human being	They saw you as a person
	3b: Feeling safe within the relationship	I felt safe with her
	3c: The attuned practitioner	It's like having a really strong father figure
	3d: Effective treatments	I started getting the correct treatment
	3e: The painful loss of the helpful practitioner	No one to go to

whilst Joan, Paul, and Martha spoke in more depth about their experiences of mental distress. Joan stated:

Yeah it was pretty scary that first time. Cause I felt as though I was on a train going towards death and I couldn't get off. It might stop and be diverted a few times, but it just didn't matter what I did, I was heading for that blackness.

In this quote, Joan used the metaphor of 'blackness' to represent death. This extract illustrates the emotional fear, powerlessness, and hopelessness Joan experienced. Her mental torment felt like a runaway train, and she expressed a sense of futility at trying to stop it propelling her towards death.

Help-seeking. The participants' relationships with mental health staff were based on a help-seeker and caregiver dynamic. The participants stated that they wanted help from mental health services and staff 'to get better' and 'to be fixed'. This often referred to them wanting help to stabilize the symptoms of their perceived illness, help to ease their emotional pain, support to manage practical social problems, and time to talk about their problems with an empathic practitioner. Many of the participants described wanting to understand the reasons for their distress and to gain knowledge about how to find effective help. Ryan noted:

It felt like I was going into a garage with your car and saying, "my car's broke". Then them saying, "oh we'll fix it", and you asking what it is and them saying, "we'll fix it but we won't tell you what's wrong with it". So that left me in the dark.

Ryan described feeling his mental health practitioner was withholding knowledge that could help him understand his problems better and this left him with a sense of feeling lost. The participants in this study wanted treatments from mental health services that cured the symptoms of what they perceived as an 'illness'.

The mental health system experienced as disempowering and dehumanizing. There was a dominant theme throughout the participants' accounts about feeling dehumanized and disempowered in mental health services and how emotionally damaging this felt. Fayah recounted an experience of being completely disempowered when being forcibly fed on an eating disorder unit:

I was pulling them all out and they were pushing them all back in. And no one explained to me why they were doing it. For me, that was a big issue with control. The more severely ill you are, the more you need to be told what's happening to you. The more you need to know.

Fayah experienced being terrified and powerless in response to being force-fed without an explanation. She had been too unwell to express her need to know what was happening, but on reflection felt she needed to understand why they were treating her this way so she could have regained some sense of control over the experience.

Traumatic experiences within relationships

The participants recounted many traumatic experiences in mental health services. They explained how difficult it was to trust mental health practitioners, described relationships with staff that further diminished their own self-worth, and talked about the harmful effects of the treatments provided. These perceived threats led to them reacting defensively in their relationships with practitioners.

The unknown practitioner. The participants found it difficult to begin new relationships with other people, including people who worked in mental health services. Joan stressed the importance of needing to know that a practitioner could help before being prepared to trust and open up about her personal problems in a new relationship. Often the participants were suspicious of unknown staff due to an intense fear of being sent back to an inpatient ward. Fayah said:

The biggest fear is her not knowing how to handle the situation, telling me to go and see my psychiatrist and they'd stick me in hospital. That's the biggest fear I have.

Fayah viewed her new social worker as a potential threat. She had spent 6 years as an inpatient and was terrified of having to return. She was not willing to be honest about her psychological distress due to the threat of being sent back to hospital. This fear of hospitalization was shared by the other participants, and it dictated how they behaved in their relationships with mental health practitioners.

The relationships that diminish self-worth. The participants spoke about the unequal power dynamics with mental health practitioners on inpatient hospital

wards. Joan talked about a traumatic consultation with a psychiatrist who she felt took her control away:

He made me feel small, he made me feel frightened.

Joan explained how important it was for her mental health to have a sense of control and how by taking it away the psychiatrist had left her feeling diminished, threatened, traumatized, and defensive. Rebecca referred to her experience in hospital like reliving the loss of control she felt when she was abused as a child. Rebecca stated:

... it was just like, oh my god this is not treatment, this is abuse. It was just horrendous, it really was.

The participants described feeling ignored and disrespected by mental health nurses on hospital wards. The lack of respect in their relationships with staff left them feeling they were being treated like 'animals' or 'children', experiences that heightened their psychological distress.

Given treatments that didn't work. All eight of the participants talked about treatments from mental health services that were not effective at relieving their symptoms of mental distress or had a damaging effect on their physical or mental health. The treatments discussed were psychotropic medications, talking therapies and Electroconvulsive Therapy (ECT). Fayah talked about her experience of being treated with ECT thirty-five times in the last year:

Explain to me, why am I having it so many times and why is it not working? And why did it take them ten years to realise that ECT is not the answer.

Fayah, Marcus, and Rebecca expressed anger about having to endure years of ineffective and harmful treatments. This culminated in them being resentful and suspicious of mental health practitioners. Harley and Fayah both said they had felt treated like a 'guinea pig' by psychiatrists.

The patients' defensive reaction. In response to feeling threatened, disempowered, unsafe, and vulnerable in mental health services, the participants lied, became passive or disengaged from mental health practitioners to regain a sense of control and protect themselves. Marcus stated:

If you don't get empathy from someone, then you're not going to work with them.

Others came to the conclusion that the hospital environment was not an effective environment to help them overcome their mental health problems. For instance, Rebecca notes:

In the end I just thought, right, I'm going to have to do whatever they tell me to do and get out of here now. And I think I just complied with everything and got discharged.

Joan, Marcus, Rebecca, and Fayah described learning over many years that they had to protect themselves from the existing mental health system and the practitioners who worked within it. Their responses to the threats in mental health services were an attempt to regain a sense of power and control using whatever resources they had available to them to defend themselves. For Fayah, her responses to these threats were to harm herself because she said her body was the only thing she had left that she felt she had any control over.

Helpful and transformative relationships

A notable area of divergence between the participants was the difference in the connectedness of relationships they had established with some mental health practitioners. Marcus, Joan, Fayah, Jordan, and Rebecca all gave accounts of experiencing secure, strong, trusting, and emotionally attuned relationships with some specific mental health practitioners. These practitioners were greatly valued by the participants and experienced as being extremely effective at helping the participants to feel better. These were consistent relationships that had lasted from between 1 year to over 10 years. The participants talked about helpful relationships with psychotherapists, social workers, support workers, CBT therapists, key workers, psychiatrists, and psychologists. These relationships had helped the participants to feel emotionally stable, more in control and had eased their levels of distress. In contrast, Martha, Paul, and Harley did not report developing significantly close relationships with any mental health practitioners.

Being treated as a human being. For the participants 'being treated as a human being' helped to improve their own sense of self-worth. When staff treated them as a human being, they instilled a sense of dignity and respect in the participants. They did this by taking the time to get to know them, demonstrating they cared, listening, and putting effort into developing a trusting and secure relationship. These relationships were greatly appreciated by the participants and encouraged positive change. Rebecca explained that what stood out about helpful staff was

...their demeanour, the way they spoke to people, like they were treated like human beings and not farm animals. Just more respect I think.

The participants valued practitioners who saw them as unique individuals and treated them as 'living breathing human beings' and not just as patients.

Feeling safe within the relationship. The participants talked about feeling safe in their relationships with helpful practitioners. Joan stated:

I knew I could tell her stuff, trust her and that she would use the information in the right way. That she wasn't going to cause me any harm. I felt safe with her.

It was crucial that the participants felt safe before they were willing to open up about their inner distress and past traumatic life experiences. It took Rebecca 6 months with her psychotherapist before she felt secure enough to take her coat off, and Marcus said it took him 2 years before he could trust his psychiatrist. Feeling safe in these relationships was

the first step to being able to learn new ways of approaching, understanding, and overcoming their distress.

The attuned practitioner. Rebecca, Marcus, Joan, and Fayah all described developing strong emotionally attuned attachments to certain mental health practitioners. These relationships had often lasted many years, and the participants conveyed a strong sense of gratitude towards these practitioners. Marcus described how he experienced the close bond with his psychiatrist:

It's like having a really strong father who understands you. There's a closeness there. He understands everything about me. He knows how I work, my mood swings. He knows everything. And he can see when I go in if I am lying or not, and he drags it out of me. He really does. So, I get a proper treatment then. He gets a true, full understanding of me, so he's able to treat me.

Marcus and Rebecca both compared their relationships with emotionally attuned caring practitioners to being like relationships with a nurturing parent or grandparent.

Receiving effective treatments. When practitioners understood and put the participants' needs at the centre of decisions about their care, the participants said the treatments provided were more effective. Fayah described her experience with a helpful inpatient ward psychiatrist:

He [ward psychiatrist] listened to what I was saying. He took everything very slowly. He went at my pace, listened to my concerns and to any worries I had about side effects. If I wanted to come off a medication because of the side effects he was there. If I needed help with sleep, he'd say "right we'll find a way around to help you".

Fayah explained that the psychiatrist's actions of listening, letting her lead the pace of treatment, and acknowledging her worries about the side effects of treatments effectively helped to stabilize her symptoms, resulting in an earlier than planned discharge from hospital and the sustained stabilization of her mental health difficulties.

The painful loss of the helpful practitioner. Feelings of safety and trust in relationships with helpful practitioners had often taken many years to develop. When these relationships ended, the participants described a deep sense of loss. The end of these relationships was a loss of a caregivers' in-depth knowledge about their difficulties. Importantly, these practitioners could be trusted to keep them safe when the participants felt unable to trust themselves. For the participants, these helpful practitioners could not be easily replaced. For example, Fayah stated:

I know it's not their fault, but it's the systems fault. It just leaves you insecure. You feel like that little lost person again. You've got no back up support. You've got no strength, no one to go to if you need support, no one to go to if you've got a problem.

Paul, Fayah, Marcus, and Joan all spoke about practitioners who they had felt strongly attached to and they described how painful the endings of these relationships had been for them, especially in cases where there had been sudden endings or endings with no opportunity to say goodbye.

Reflexive analysis

The reflexive activities chronicled how research decisions were considered alongside the committee members of the mental health charity and the participants. These decisions occurred within the context of the primary researcher practising as a psychologist within mental health services. Thus, whilst aiming to empathize with the participants' accounts in the analysis, the influence of working as a professional psychologist was also discussed. The mind mapping activities therefore explicitly included a reflective element in which the relationship between the interviewer and each participant was analysed drawing on humanistic and psychodynamic theories.

Notes from journals, mind maps, supervision, and conversations with the committee members chronicled the development of the conceptualization of the cross-cutting relational components of *power*, *safety*, and *identity*. The anonymized findings were presented to a support group at the mental health charity. The attendees expressed an emotional connection to the analysis and reported that they were representative of their experiences in mental health services.

Discussion

As indicated at the outset of this paper, it is widely accepted that the therapeutic relationship is the centre piece of psychiatric practice (Cutcliffe, Santos, Kozel, Taylor, & Lees, 2015; Priebe & McCabe, 2008). This project therefore sets out to explore this further and consider what might constitute helpful and unhelpful aspects of these relationships. In summary, and in contrast to the accepted importance of the therapeutic relationship, the findings of this study show that the participants struggled to find relationships that they experienced as therapeutic in the mental health system. As with previous research (Bracken & Thomas, 2001; Rogers, Pilgrim, & Lacey, 1993; Russo & Sweeney, 2016), the interviewees' reported that they were commonly treated as an animal or patient, rather than a human being. The persistence of this viewpoint in the history of mental health services proves concerning (e.g., Bracken *et al.*, 2012) and highlights the need for organizations to scrutinize their ways of working with these viewpoints in mind. In particular, we would argue that the findings here demonstrate that this shift needs to be based on providing more *care* and less *control* within the current system of psychiatry.

Although the participants in this study had numerous negative experiences, a number of the interviewees here did have experiences with some staff that provided greatly valued support and help. Within the three superordinate themes, the participants reflected upon the higher-order concepts of *power*, *safety*, and *identity* as relational components fundamental to their experience of either being helped or harmed in their relationships with mental health practitioners. Figure 1 provides a visual illustration of this process and outlines a Power Safety Identity (PSI) model of relationships in mental health services that might be utilized in reflexive activities such as clinical supervision (Hanley & Amos, 2018). It highlights the interaction between the service user and the

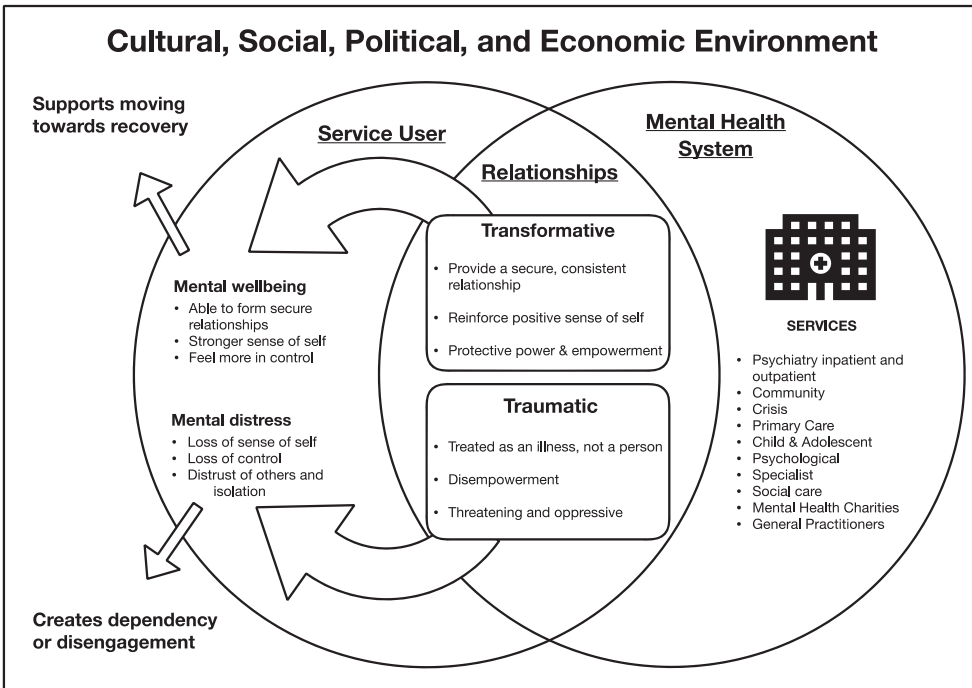


Figure 1. The Power Safety Identity model of relationships in mental health services.

mental health service and indicates how relationships with professionals can prove transformative or traumatic in nature.

The PSI model articulated here provides a conceptual understanding based upon the interviewees’ experiences and is informed by the related literature. It aims to highlight how relational elements associated with *power*, *safety*, and *identity* are embedded within relationships in mental health services and have important consequences for service users (as exemplified by within the findings section of this paper). The PSI model of relationships resembles long-standing arguments evident within the humanistic psychology (Bugental, 1964; Hanley & Winter, 2016) and service user movements (Chamberlin, 1978) that call for more holistic perspectives on psychological distress. More recently, the *Power Threat Meaning (PTM) Framework* (Johnstone & Boyle, 2018) published by the British Psychological Society’s Division of Clinical Psychology echoes similar sentiments. This document identifies the importance of power, responses to threat, and identity in understanding the lived experience of psychological distress. It contends that meaning is intrinsic in all forms of emotional distress that is based on universally evolved human capabilities and threat responses. Given this, the reflexive PSI model described here has the potential to contribute to the PTM framework by providing an understanding of how service users experience power and threats in their relationships in mental health services.

The PSI model can help practitioners to understand and reflect upon the power-based tensions they experience in their relationships with service users. Based upon the experiences of those involved in this study, it is also argued that having an understanding of *power*, *safety*, and *identity* in these relationships can improve the quality of care provided by mental health professionals/services. Powerlessness, loss of sense of self, and

loneliness can be both the causes and the consequences of mental distress (Tew, 2011). The interviewees' experiences here reflect that when these are reinforced through relationships in mental health services, psychological distress can be heightened and recovery hindered. Alternatively, if mental health workers are able to create relationships with service users that provide a consistent, safe, and trusting relationship, then these could help to promote recovery. Such relationships might be viewed akin to the warm, genuine, and accepting relationships outlined in the theory associated with client centred therapy (Rogers, 1957).

Power

The analysis illustrates how the participants experienced the power of the institution of psychiatry through their relationships with staff and how this emotionally affected them (e.g., Fayah feeling suspicious of professionals when they neglected to provide information about the treatment she was receiving). Smail (2005, p. 33) conceptualized individuals as being surrounded by a spatio-temporal 'power horizon'. The power horizon describes how institutions of power operate through complex lines of influence through connections with other institutions and the individuals within them. He convincingly argues that people can have little awareness of the forces of power that surround them due to the limited access to knowledge about them. Cutcliffe and Happell (2009, p. 122) suggested that to create helpful relationships in psychiatry services it requires practitioners to be self-aware and mindful about how they use 'invisible' power within their professional roles. Tew (2011, p. 50) also describes the importance of 'protective' power in the context of mental health. Protective power, which can be seen reflected in the work of attuned practitioners noted above, can be used temporarily as a way of providing holding or comfort in times of crisis or vulnerability.

Safety

This study conveyed how threatened service users can feel in their relationships in mental health services. The participants' narratives illustrate how perceived threats heightened embodied biological and emotional distress which they responded to in a defensive manner (e.g., as with Rebecca's withholding information). In traditional mental health practice, these responses would be understood as 'symptoms'. However, in this paper, the participants were able to provide first-hand accounts of the meaning of these threat responses of either automatic bodily reactions or consciously selected responses that they used to ensure emotional, physical, relational, and social survival.

It is commonly accepted that humans have a basic human need to feel safe in relationships with others (e.g., Bowlby, 1951). Feelings of security within relationships have an immediate impact on bodily affect responses. Yates, Holmes, and Priest (2012) research into the types of environments that assist recovery from severe mental illness highlights the importance of people being in environments that enable them to feel safe and secure. Fonagy and Campbell (2015) declared the importance of epistemic trust, which they described as 'the driving force for therapeutic change' (p. 243). They claim that when epistemic trust, attachment (a secure base), mentalizing (being understood and understanding the other), and the social environment work in synergy, this can then enable a person to learn from their wider world and make positive changes.

Self-identity

By entering a psychiatric system dominated by the biomedical ‘disease’ model, service users can instantaneously experience being dehumanized (as is evident in the first superordinate theme). This model typically focuses upon the symptoms of distress and denies the existence of the meaning underlying their distress. As noted earlier, this ‘disease’ model is challenged by humanistic psychologists who advocate holistic growth-focused approaches to psychological support (Bugental, 1964) and the service user movement (Chamberlin, 1978). Despite this long history of challenge, the biomedical disease model remains predominant, however. More recently, the findings from previous service users experience-based research show repeatedly that people in severe psychological distress want to be seen and treated as a unique individual or ‘human being’ rather than as a set of symptoms or an illness (Bracken & Thomas, 2001; Rogers *et al.*, 1993; Russo & Sweeney, 2016). Further, Eriksen, Sundfør, Karlsson, Råholm, and Arman (2012) identified dignity as being a major factor in the experience of being treated as a human being. The concept of dignity is integral with ideas about ethics, values, and social justice. Health care policy documents are full of rhetoric placing dignity at the heart of quality health care (e.g., Department of Health, 2008). The concept of dignity is a useful one as it places the individual within a social context in the arenas of human rights, law, and social justice. Mental health practitioners, who are accepting and valuing of service users in whatever state or situation they are in, provide an opportunity to strengthen the service users’ self-identity and empower them to make meaning of their experience (Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014; Rogers *et al.*, 1993). The participants’ in this study reported a lack of experiences of these types of relationships in psychiatry services. This lack of care and focus on control of people suffering with severe emotional distress raises fundamental questions about western society’s assumptions about the meaning and value of humanity.

Limitations and suggestions for further research and interventions

A core strength to this work is its collaboration with individuals who have utilized mental health services. This has helped to enrich the research and led to the creation of longer-lasting relationships between the named researchers and the collaborating organization. As has been chronicled elsewhere, such relationships bring with them their own challenges (e.g., Gillard, Simons, Turner, Lucock, & Edwards, 2012) and, with the benefit of hindsight, this study may have been conducted in a more egalitarian way that may have led to further benefits for all involved. Although further engagement was not possible within the scope of this project, it is recommended that further work exploring service users’ experiences consider more fully how individuals can support the coproduction of research.

Through the adoption of an in-depth qualitative design, this study provides a rich account of the experiences of the participants. IPA-based research has been criticized for only using small sample sizes (Pringle, Drummond, McLafferty, & Hendry, 2011); however, the depth of analysis allowed here helps to vindicate such designs. As such, although broad generalizations based on the findings cannot be made and are not the intent of IPA, the transparent and contextualized analysis should enable the reader to consider the theoretical transferability of the work.

In order to gain insights into the interpersonal nature of relationships in psychiatry settings, further research is needed asking mental health practitioners, service managers, and commissioners about their experiences and perceptions of how relationships with

service users help or hinder recovery. In particular, it would be helpful to explore in more depth the concepts of *power*, *safety*, and *identity* from multiple perspectives.

Conclusion

The findings of this research contribute to the long-standing debate for the need of a paradigm shift in mental health care. By synthesizing how service users' experience relationships with professionals, it provides a poignant and evocative reflection of what it can be like to engage with the mental health system in the United Kingdom. Specifically, this research contributes to the growing body of the literature that supports the need to humanize psychiatric services. It is argued that changes need to be based on providing more *care* and less *control* within the current system of psychiatry. As such, it is recommended that services, and the professionals within them, should proactively reflect upon how the relational components of *power*, *safety*, and *identity* impact upon their work so as to improve the quality of care for people in severe distress. To aid this process, the PSI model suggested here can be used as a tool for reflection. This has been created as a response to the experiences of service users and advocates a more humanistic approach to mental health care. To end, we return to the words of one of the participants that sum up much of the core sentiments of this model. The participant, Marcus, was talking in the interview about an experience of feeling cared for on an inpatient ward. He described eating with staff and them showing him an attitude of respect. When asked how this made him feel, he said:

Well, like a human being. I was an equal. I wasn't just a patient.

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