THE GOLDILOCKS PARADOX: CONSTRUCTIONS OF READINESS FOR THERAPY ON ADULT ACUTE WARDS

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ABSTRACT

The aim of this thesis is to explore how clinicians working in adult acute settings construct their understandings of readiness for therapy, utilising a Foucauldian discourse analysis (FDA).

The first part presents a critical review of the literature considering the multifarious discursive constructions of readiness for therapy. These are considered in relation to the differing therapeutic approaches, illustrating the socio-historical construction of this concept. Constructions of readiness for therapy are also considered in relation to the lack of research and treatment development in inpatient acute settings and the inherent implications for this absence: primarily lack of provision of, or access to, therapy.

The analysis is then presented, employing semi-structured interviews to explore how five clinical psychologists and five psychiatrists conceptualise the construct of readiness for therapy in their work in acute inpatient psychiatric settings. Transcripts were analysed using an FDA.

The thesis adopts a critical realist social constructionist epistemological position in order to facilitate the exploration of readiness for therapy as a construct both at the level of discourse in the text and at a wider institutional level. This position also enables consideration of contextual and social factors and their implications for subjectivity.

The analysis demonstrated that clinicians constructed their understandings of readiness for therapy in three main ways. They constructed readiness for therapy in relation to the requirement for a particular ‘ideal’ therapeutic subject constituted through processes of subjectification. They constructed ‘unreadiness’ for therapy as a tool to support their position as ‘expert’ through disciplining practices of surveillance and coding. Finally they constructed broader service contexts - service structures, regulatory guidance and therapy itself - as barriers to their ability to provide therapy in this setting; thus facilitating their subject-positioning as ‘ethical’ practitioners.

As a consequence of these discursive constructions it is therefore very unlikely that patients in these settings would fulfil criteria necessary for them to be considered ‘ready’ for therapy and to thus have access to therapy.

This thesis recommends utilising the Power Threat Meaning framework (Johnstone & Boyle, 2018) to enable dominant biomedical discourses to be challenged in facilitating differing constructions of readiness for therapy, more suited to the context of inpatient acute settings. The lack of and need for research in this clinical area is acknowledged. Recommendations are made that therapeutic approaches should be pragmatic and flexible in their attempts to meet the needs of the patients admitted to inpatient acute wards.

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CHAPTER ONE: INTRODUCTION

Conceptualisations of readiness for therapy (hereafter referred to as RFT) are multifarious and multidimensional. From engagement, psychological mindedness or stages of change, to assessment scales focusing on 'insight' and a profusion of published research in this area; the assumptions underpinning the use of these ideas, whether overtly discussed and assessed or indirectly expressed, enter into many clinical discussions and have the capacity to influence treatment decisions and access to therapy. The problem this study aims to address therefore relates to how RFT is constructed in inpatient settings and the implications of these constructions for subjectivities and for practice.

In order to address this question, I will take a Foucauldian frame to understanding RFT. This frame enables us to view RFT as socially constructed and culturally and historically situated whilst also facilitating an exploration of the impact of discursive practices on subjectification and on material outcomes relating to access to therapy. Analysis in the Foucauldian sense understands language as being more than the means to communicate and translate our experiences into words. Rather, the experiences themselves are formed by the ways they are expressed and understood in language (Oksala, 2016). The 'linguistic turn', one of the most important shifts in Western philosophy during the twentieth century, thus opens up new avenues for understanding the nature of reality and is crucial in comprehending processes of subjectification.

Subjectification, taken from the French "*assujetir"* meaning both to make subject to and to produce subjectivity (Henriques, Hollway, Urwin, Venn & Walkerdine, 1998), involves the construction of identity as social, historical and culturally located. Identity is seen here not as static or reified, but as relating to a subject who is continually co-constructed in social action (Burr, 2003). Foucault's writings focused on the production of certain types of subjects: the mad, the ill, the criminal (McHoul & Grace, 1993) through discourse, within the power/knowledge networks of society. Power relations thus shape behaviour and awareness and are constitutive of the subjects themselves (Oksala, 2016).

Through exploration of how ten clinicians working in adult inpatient acute settings construct their understandings of RFT, this research will address the construction of RFT in relation to processes of subjectification.

The introduction will first provide context regarding the nature of in-patient settings in the UK, their history and current construction. It will then address the provision of therapy in these settings and policy recommendations for clinical practice in this area. Constructions of therapy will then be addressed. There will follow a literature review regarding RFT, which will critically examine how this construct is functioning in the literature and how it is addressed in relation to inpatient settings. Finally it will outline why this issue may be problematic in the context of inpatient settings.

1.1 Language

For the purposes of this study the term ‘therapy’ will refer specifically to *psychological* therapies and exclude other types such as occupational therapy. Throughout this thesis the phrase ‘RFT’ will be used to describe a broad set of phenomena and research, which contains alternatives and subcategories to this concept. The various constructs which can be seen to come under the umbrella of RFT, or a similar group of ideas, have been present for a long time in ways that people talk about therapy and psychiatry. This phrase was chosen as a term that is regularly used in clinical practice and would be easily understandable to participants as a naturally occurring part of their working language.

Whilst wishing to remain aware of and avoid the use of pathologising language, in describing the subject constructed by the participants in this study, the word ‘patient’ will be employed. This choice of construction is acknowledged to be a thorny issue, especially taking into consideration the processes of subjectification explored in this study and the looping effects of “human kinds” (Hacking, 1995). For a group that has experienced and endured a long history of stigmatization, careful consideration of use of such a label is especially pertinent. The reasons for use of the term ‘patient’; as opposed to ‘client’, ‘service user’, ‘survivor’, expert-by-experience’, ‘consumer’ or any other number

of terms, which have sprung up in attempts to address the inherent tension created by the use of the word ‘patient’ in these contexts are manifold: firstly, in surveys participants have been found to prefer the word “patient” (Upton, Boer & Neale, 1994; Ritchie, Hayes & Ames, 2000). Secondly, the language, throughout the data, of madness and distress construct these experiences as mental illness with inherent implications of parity with physical health. Additionally, this choice reflects the language frequently, but not always, used by the participants interviewed. Finally, the choice to use ‘patient’ reflects the setting: in which many of the people on the ward are there compulsorily, are not choosing to use services as a ‘client’ or ‘service user’ and are not positioned as ‘expert’ in the power-knowledge nexus. My choosing to use the term ‘patient’ is therefore consciously done to make explicit the lack of agency, which is, in itself, a form of resistance.

1.2 A History of Inpatient Settings

In Madness and Civilization (Foucault, 1965), Foucault describes how, following the waning of sovereign and religious power during the Enlightenment in Western societies, rationality became an organizing principle of how society functioned. Madness was no longer seen as ‘unreason’ in dialogue with reason. It was excluded and opposed to what was rational and, in essence, human. As a result of this process the mad were not only physically confined and isolated but also excluded on a conceptual level from the realm of reason and humanity (Oksala, 2007). In the late 18th century madness underwent another change and was understood as mental illness. The birth of the psychiatric asylum was, by traditional explanations, a ‘liberation’ of the mad; a recognition of the ‘true’ nature of madness as mental illness. County asylums were built and legislation such as the Shaftesbury Acts (Cooper, 1845) supported the ‘regulation of the care and treatment of lunatics’ (Hunter & McAlpine, 1974, p254). Foucault, however, argues that the insane, although no longer confined by chains and cells, were now just as imprisoned by the strict moral rules and values of the ‘liberators’.

The madman as ‘patient’ now under the complete authority of psychiatric knowledge. Foucault’s aim was to demonstrate the grounding of modern, so called ‘humane’, conceptualisations of madness as mental illness, in historical

practices of confinement. Whether or not we accept Foucault's reading of this history, one can say that in 1954, shortly before the process of deinstitutionalization was initiated, asylums housed approximately 154,000 people. Minimally funded and overcrowded, they comprised 40 % of inpatient beds in the NHS whilst receiving only 20 % of the hospital budget (Goodwin, 1996).

1.3 Deinstitutionalization

Against a background of changing social attitudes to mental illness, emphasizing human rights, the 1959 Mental Health Act determined the community as the most appropriate context of care for people with mental health problems. In 1951, the then Health Secretary Enoch Powell gave his now-famous 'water-tower' speech condemning the asylums. Addressing the transition to community-based care, his speech set events in motion for the shift to community care. The development of community-based alternatives to hospital care has since gone through a plethora of developments in relation to emerging research and changes in social context. It is beyond the scope of this study to outline these developments in detail. However, the closure of the asylums was completed and, outside of a few large-scale forensic units, no large-scale institutions in this model of care now exist in the UK.

1.4 Current Practices and Structures in Acute Inpatient Services

Bed numbers available for mental illness dropped from a peak of approximately 150,000 in 1955 to 22,300 in 2012, with a 62.1 % reduction from 56,112 to 18,630 between 1986/8 and 2015/6 (Ewbank, Thompson, & McKenna, 2017)). Over-occupancy is a common issue with a Freedom of Information request finding an average inpatient ward bed occupancy rate of 101% and some wards operating at 134% capacity in August 2013 (Crisp, Smith & Nicholson, 2016).. The raising of admission thresholds, was found by Mind's (2011) enquiry to be a recurrent theme with patients being told they were 'not ill enough' or 'too ill' in some cases, to meet admission criteria (Mind, 2011). By 2013 the UK had 54 psychiatric beds per 100,000 compared with the OECD average of 58 (Hewlett & Moran, 2014). There have been suggestions that reductions in bed numbers

“may have gone too far” (Crisp, Smith & Nicholson, 2016) and that inpatient care has been unnecessarily demonised within the field of organisational research (Kapur et al, 2016).

Moreover, it has been argued that a process of reinstitutionalisation is already underway and is happening largely unnoticed by the public and with minimal professional debate. This process, it is claimed, is occurring both via an increase in forensic beds and supported housing placements and through institutionalized cultures remaining the same either within community teams or in the context of smaller acute wards (Priebe et al, 2005).

1.4.1 The Population of the Ward

Due to these longstanding policy objectives of community-based alternatives to hospital care, the severity of illness in inpatient settings has increased (Gilburt, Peck, Ashton, Edwards & Naylor, 2014). These changes have also had an impact on the mixture of diagnoses on inpatient wards with a higher proportion of patients with diagnoses of psychosis or schizophrenia and significantly reduced admission rates for those with affective disorders (Hunt, Rahman, While, Windfuhr, Shaw, Appleby & Kapur, 2014). It has been well established that psychiatric illness rates are higher in black and minority ethnic (BME) groups, with findings of significant and sustained differences in experience of mental health services and outcomes of interventions between the white majority and minority ethnic groups (Cochrane and Sashidharan,1996). Black Caribbean patients with a diagnosis of psychosis or bipolar disorder, for example, are more likely to be detained in hospital compulsorily (Commander, Odell, Surtees & Sashidharan, 2003) whilst higher rates of hospital admissions for mental health problems for people from black and minority ethnic groups who are more likely to be detained under a section of the Mental Health Act, more likely to be medicated and more likely to experience a poor outcome from treatment, have been well documented (Sashidharan, 2003).

1.4.2 Experiences of Being on the Ward

A crisis care report by Mind (2011) found that many people reported experiences of “dirty wards, lack of human contact, a lack of respect often bordering on rudeness by staff, and a reliance on force” (p. 5) suggesting that

mental health services have lost touch with basic humane principals (Mind, 2011).

"Quality of life on the ward was terrible, it was a violent place to be. I was repeatedly hit and had things stolen but most of the nurses did not care. The hospital was filthy and the staff stressed and over-worked, access to different therapies was non-existent. They moved my bed eight times in four weeks! Mostly without my knowledge till I tried to find my bed and belongings."

"On the ward, my care was a knock on the door at 10am to go and get my meds, and a knock every few days to see the psychiatrist. I had no one-to-one conversations with any nurses or support workers except one when I spent a day on eyesight obs. I felt extremely safe on the ward, and benefited from speaking to others with mental health problems. I got more 'therapy' from them than I did any of the staff."

(Mind, 2011, p. 22).

Patient feedback on the experience of being on the ward is evidently overwhelmingly negative, with reports of a lack of activity, little interaction or therapeutic input and widespread issues around violence and risk.

1.5 Constructions of Therapy

It is outside the scope of this thesis to provide a comprehensive account of the origins and history of therapy. This section will therefore outline therapy from three perspectives: Firstly a definition of how therapy will be conceptualised for the purposes of this study. Secondly a reflexive statement of my own position in relation to therapy and finally a critical account of how therapy is rendered problematic in relation to critical and Foucauldian perspectives, comprising the main theoretical approaches to therapy in the West.

As stated, the term 'therapy' will refer specifically to *psychological* therapies. Due to the participants' professional qualifications and positions in inpatient

services - as psychiatrists and clinical psychologists - the majority of discourse in the data relates to therapy as provided by clinical psychologists.

My own position in relation to therapy has shifted, perhaps foreseeably, over the course of carrying out this piece of research. I approached the study from the perspective that therapy is a force for good, enabling change and providing support in times of emotional distress. Whilst I still believe that therapy can be a positive entity in many situations, my analysis and reading has heightened my awareness of its more problematic aspects. These will now be outlined below.

Since the 1950's therapy, under the broad umbrella of treatment of mental illness, has been critiqued as part of a power-knowledge nexus around mental health and distress. R.D. Laing (1967) and his followers maintain that treatment of mental illnesses such as psychosis represents a means of avoiding the political issues involved such as family difficulties and societal pressures. Therapeutic regimes in hospitals, according to this viewpoint, are expressive of a societal desire for its members to behave in an appropriate and economically productive manner. Thomas Szasz (1974) elaborated on the antipsychiatry movement as conceptualized by Laing. He argued that the representation of madness as a disease is fundamentally a category error (Ryle, 1949) born of confusion over the nature of mind as conceptualised by Cartesian metaphysics; an error in philosophical judgement which, in creating the 'myth' of mental illness, has given the medical profession a dangerous authority to imprison and manipulate the mad under the guise of benevolence (Miller, 1983). With its roots in the work of Foucault, Donzelot and Castel, the psy-complex, as formulated by Ingleby (1985) and Rose (1985) refers to all disciplines that concern themselves with mental health and can be seen to highlight the emergence of psychology as an administrative technology of assessment and surveillance within modernizing state apparatuses (Burman, 2015). More specifically, in relation to therapy, Rose formulates the psy-complex within notions of governmentality as a method of self-knowledge productive of reflexive, self-regulating subjects (Burman, 2015). Rose (1990) has suggested that psychology is attractive to all modern, or modernizing, societies, in part as a result of its capacity 'to achieve socially desirable objectives through the disciplining of human differences, amongst other things' (Louw, 2005).

Therapeutic psychology, argues Smail (2011), manages to "obscure from our view the full significance for our emotional suffering of the workings of material reality" (p. 226). More recently the subject position of 'consumer' as opposed to 'patient' or 'survivor' (Speed, 2006) has arisen within government policy rhetoric, based on a belief in the importance of choice and of competition between providers and the 'personalisation' agenda (Holloway, 2012). As Rose outlines, this discursive positioning is tied inextricably to neo-liberal discourses of individualization and 'responsibilization' (Rose, 1999), placing increasing weight on the responsibility of individuals to manage their psychological well-being. This delineates it as something the healthcare 'consumer' has a choice to access, thus keeping the focus on the individual rather than the society they live in and serving to further minimize the perceived impact of social inequalities (Speed, 2006).

Before proceeding to a critical analysis of the literature it is necessary to provide some context as to the philosophical delineation of the main therapeutic approaches as they relate to RFT.

1.5.1 Psychoanalytic Approaches

The fundamental proposition of psychoanalytic thinking: that unconscious processes: thoughts, defences and drives, are dynamically interacting and engaging outside our conscious recognition, created an important shift in the positioning of the subject. From the rational subject of the classical period - one who acquires knowledge empirically, via sensory experience i.e. observation (Psillos & Curd, 2013) - to one with an unconscious, operating outside the realm of rationality and reason. Thus the concept of a rational subject is replaced with the de-centered subject, throwing into doubt Descartes' "*cogito ergo sum"* by questioning the place of a conscious ego as a source of thought. Processes of subjectification in psychoanalysis thus construct the therapeutic subject as one who can gain self-knowledge through the expertise of the analyst (Temperley, 1984), thus positioning the analyst as 'expert'. Foucault's concept of the confessional (Foucault, 1982) as a technology of power is a key concept in this context. As the scientific revolution progressed, knowledge that had been deployed through religious technologies of power, shifted to psychological knowledge whereby the individual is required to divulge intimate and personal

information no longer to the priest but to the analyst. As Smail (2011) underlines: Freud “poured scorn on religion as a means of containing and disciplining the masses, but certainly does not notice that in proffering psychoanalysis as the (scientific) answer he is simply replacing one opiate with another” (p, 232).

1.5.2 Cognitive and Behavioural Approaches

Behavioural techniques emerged during the 1970’s in response to the dominance of the psychoanalytic approach. More recently cognitive behavioural therapy (CBT), developed by Aaron Beck through the integration of cognitive and behavioural theory, proposes that people can become stuck in dysfunctional patterns of thinking and behaviour, the cognitions are seen as affecting our emotional and behavioural responses and as patterns of thought which can be changed through individual efforts. CBT is currently a privileged treatment approach, institutionally sanctioned within inpatient settings (Taylor & Perera, 2015). Treatment for schizophrenia, for example, commonly involves a combination of antipsychotic medication, social support and CBT or family therapy (NICE, 2014). The clinician’s judgement about the correct way for the subject to think about their experiences is privileged as they identify “negative automatic thoughts” through normalizing processes of subjectification. Positioned epistemologically within a realist method of research, CBT thus aligns itself to the dominant biomedical framework.

Both psychoanalytic and cognitive approaches share an assumption of individual pathology, whereby ‘faulty cognitions’ or ‘defence mechanisms’ are located in the individual and thus wider contextual factors are not privileged. This assumption of individualism, supported by the minimization and distancing of negligibly acknowledged contextual factors, has been argued by Boyle (2011) to be a ‘safety behaviour’ enabling the continuance of the biomedical model. Thus using a diagnosis such as schizophrenia and a therapy such as CBT for psychosis (CBTp) may serve to obscure the impact of context, depoliticizing distress by disregarding the impact of trauma, inequality and abusive social structures, negating political and public responsibility in addressing these difficulties and placing responsibility for change in the distressed individual

(Patel, 2003). As noted, the role of the psy-complex is crucial in perpetuating this worldview. The use of assessment to ascertain RFT can be seen to function as a technology of power, constructing ‘readiness’ as a variable to be measured, locating ‘pathology’ and responsibility to change in the individual, whilst positioning significant power with the clinician as a gatekeeper for access to therapy as a resource, and constructing the patient as ‘ready’ or ‘unready’ workable-with or not.

1.5.3 Narrative Approaches

Often considered to be a postmodernist approach, narrative therapy can be seen to challenge the psy-profession’s capacity to define reality, instead focusing on language and its role in the construction and experience of the self. The positioning of power within the therapeutic relationship is shifted away from therapist as expert and toward a co-construction of meanings of experiences, reality and the person’s subjective experience of self-concept (Boston, 2000). Narrative constructions of RFT are conceptualised as a deconstruction: a move away from the focus on pathology in assessment and from the assumption that there is something ‘wrong’ with the client. The ‘intake interview’ (as opposed to ‘assessment’) is viewed as an “excavation” of the often problem-saturated dominant story and of the implicit construction of the client as “fused” with their problem (Timm, 2014).

In inpatient settings the use of open dialogue (Seikkula, Aaltonen, Alakare, Haarakangas, Keranen, & Sutela 1995), an intervention grounded in narrative and systemic approaches, is in an ongoing process of development with striking success rates for those experiencing psychosis: 81% compared with 20% in treatment as usual (Stickman, 2015). Focused on curiosity and improvisation and involving a consistent family/social network approach to care, the ‘polyphony’ described in open dialogue, whereby all voices are heard and given equal weight (Stockman, 2015), places a different emphasis on decisions about RFT.

Additionally, the recent publication of the Power Threat Meaning (PTM) Framework (Johnstone & Boyle, 2018) could be seen to be aligned to narrative approaches. It outlines a conceptual alternative to the diagnostic model of

mental distress bringing together evidence about the role of power, the evolution of threat responses, social discourses and personal meanings and narratives.[1]

In order to understand how the construction of 'RFT' is functioning within adult acute inpatient services it is important to appreciate how it has been constructed over time and in relation to differing theoretical approaches. This study will therefore employ a Foucauldian-informed approach to the literature review, interrogating the "conditions of possibility" (Foucault, 1966) in which RFT is currently conceptualized and the resultant implications for subjectivity both of the 'ready' therapeutic subject and of the clinicians who 'assess' them. There follows a literature review which seeks to critically analyse the literature surrounding RFT, examining discursive constructions from a Foucauldian perspective.

1.6 Literature Search

A systematic search was completed using PSYCHINFO and Science Direct databases. The search terms were refined through 'abstract, title, keywords' in Science Direct and 'title' and 'subjects' within PSYCHINFO. After carrying out an initial screening of the title and abstracts of the literature generated, research that appeared relevant to this study was selected. A citation search was also performed. For the purposes of this study searches were restricted to topics directly referencing mental health concerns. The terms chosen for the advanced searches were aligned to my research questions and are detailed below:

- (Readiness OR Preparedness) AND (Therap* OR Treatment OR Psychotherap* OR Psycholog*)
- (Readiness OR Preparedness) AND Change
- Motivation AND (Therap* OR Treatment OR Psychotherap* OR Psycholog*)
- Insight AND (Therap* OR Treatment OR Psychotherap* OR Psycholog*)
- (Therap* OR Treatment OR Psychotherap* OR Psycholog*)
- AND Psychological-Mindedness

[1] See Appendix A for an overview of the PTM Framework.

- (Readiness OR Preparedness) AND Therap* AND Inpatient AND Psychiatr*

1.7 Constructions of Readiness for Therapy

This literature review aims to explicate the discursive shifts which have influenced how RFT is currently constructed in relation to theoretical and therapeutic models and to norms of practice. In his studies of scientific discourses Foucault analysed the ways in which language forms an ontological order of things implicit in scientific theories and practices. The 'linguistic turn' or 'turn to discourse' (Parker, 1989) opened the way for new possibilities for thinking with language seen as constitutive, rather than simply expressive, of our experiences of the world; and, additionally, considering how language is deployed in professional contexts in both theory and practice. The language used to construct the concept of RFT has, as might be expected, shifted and transformed over time. It covers multiple terms and definitions including, but not limited to: RFT, psychological-mindedness, engagement, insight, readiness for change, suitability, and motivation. Language in the literature appears to contain multiple potential meanings relating to each term as well as elements which feed into one another, with operational definitions varying so widely within each term as to make research results challenging to summarize. For the purposes of this review, literature relating to each conceptually and linguistically differing area of RTF will be addressed in broadly chronological order, this is intended to highlight the complexity and overlap of these constrcutions as they emerged over time. Table 1 highlights, where applicable, how each area of RFT relates to the constructions of therapy outlined in section 1.5. [2] Through examination of shifts in how RFT has been constructed in the literature, this review seeks to demonstrate the constructed nature of RFT and the resultant implications for subjectivity.

Crucially RFT as an ontological reality is not questioned in the literature. It is thus enabled as a site of clinical assessment, linked to outcome and inherent in decisions of 'suitability' for, and therefore access to, therapy services.

[2] See Appendix B

Themes running throughout the literature can be seen to revolve around personality and demographic variables, psychological attributes and an awareness of and amenability to the clinical conventions of therapy. These shall be elucidated in more detail below

As a clarifying point: the language used in this thesis constructing the phenomenon being analysed as 'readiness for therapy' is, as mentioned in section 1.1, a pragmatic choice of a phrase that is regularly used in clinical practice and one which would be easily understandable to participants as a naturally occurring part of their working language. In examining RFT in the literature review, the initial section – 1.7.1 below will address RFT as represented in the literature. The subsequent discussion, in sections 1.7.2 – 1.7.6, should not be seen as subsidiary sections to 1.7.1: they are alternative linguistic and conceptual constructions of the construct of RFT present in the literature and will be examined in turn.

1.7.1 Readiness for Therapy

As discussed, RFT is an ambiguous, multifactorial construct.
Early literature addressing RFT is primarily psychoanalytic in focus. For example, Hoffman (1969) contends that an individual's defence mechanisms, activated due to the stress inherent in therapy, will predict who is likely to remain in or drop out of therapy: denial, and repression being linked to the unready client and projection and isolation to the ready client (Hoffman, 1969, p. 545). Here the reified use of psychoanalytic constructs can be seen to construct or classify the 'ready' or 'unready' subject via their defence mechanisms. Therapy itself is constructed as inherently 'stressful', a way of working into which the patient must fit.

Assessment of personality aspects is recommended to ascertain RFT (Ryan, 2001). Shanan and Moses (1961) note a preference to offer therapy to "neurotics, persons with personality disorders, and persons without a diagnosis as compared to psychotics and organics" (p. 203) and that the offer of therapy is highly correlated with the applicants' readiness to locate the problems within themselves (Shanan and Moses, 1961). Frank, Gliedman, Imber, Nash and

Stone (1956) emphasize attributes including: class, education, occupation, readiness to communicate distress and personal liabilities, influenceability, perseverance and social integrity (Frank et al, 1956). The Counseling Readiness Scale (CRS) (Heilbrun & Sullivan, 1962) evaluates RFT through separate scales for men and women. Demographics, intellectual and personality variables are considered, finding that the unready (or prematurely terminating) client has lower socioeconomic status, is male, older, less educated, and less intelligent than the ready (or continuing) client. Personality variables are also emphasized including "verbal productivity, persistence, suggestibility, dependency, ability to deal with feelings and to specify problem areas, and level of personality integration" (p. 31). All three of these studies, within the parameters of the biomedical model, can be seen to contain assumptions of individualism, paying scant attention to the part of context or social factors.

Ogrodniczuk, Joyce and Piper (2009) define readiness as "a positive attitude and preparedness to enter into a therapeutic relationship for the purpose of resolving problems". It is the focus of "patient selection…a critical task for all psychotherapists" (p 426). Numerous elements of RFT have been proposed in the literature: desire to change (Truant, 1999), readiness to make sacrifices (Hacker, 1962), willingness to talk about personal matters openly (Krause, 1966), level of distress (Schneider & Klauer, 2001; Derisley & Reynolds, 2000; Moore, Tambling & Anderson, 2013) and lack of autonomy (Pelletier et al, 1996).

Despite more recent meta-analytic findings highlighting uncertainty and discrepancies surrounding the question of relationship between demographic and personality related variables and readiness (Wierzbicki & Pekarik, 1993; Swift & Greenberg, 2015), more recent literature on readiness continues to emphasize personality variables and psychological factors (Fuller, 2013) including: proneness for subjective level of discomfort, capacity for insight, motivation and willingness to forgive (Ryan, 2001). The Readiness for Psychotherapy Index (RPI) (Ogrodniczuk et al, 2009), a self-report assessment, measures readiness via seven dimensions of RFT: level of distress, desire for change, willingness to work in therapy, recognition of

problems as psychological, willingness to discuss personal matters, willingness to endure discomfort in therapy and responsibility for change (Ogrodniczuk et al, 2009). In contrast to the CRS readiness is viewed not as a character trait but as a state that is amenable to change, raising questions (addressed in further detail in section 1.7.3) about whether criteria of RFT can be seen as prerequisite or goal.

All these approaches to defining and assessing RFT locate the difficulty within the individual and give little regard to the role of context. In this way we can understand these approaches as positioned in line with a normalising[3] agenda in the construction of a therapeutic subject with the personal resources to fulfil these criteria in order to be considered ready for therapy. As with all of the scales and measures assessing readiness, the power to assess the patient is positioned with the clinician. Additionally it is noteworthy that the creation of assessment tools is constructed within a discourse of 'evidence-base' which endeavours to account for consistency and validity of factors. Many of the processes of development of such scales rely on the examination of items by "highly experienced clinicians" (Ogrodniczuk et al, 2009) enabling a construction of the clinician as 'expert' and positioning the discursive power to construct RFT away from the patient in the power-knowledge nexus.

1.7.2 Suitability

Truant's two studies on the assessment of 'suitability' for psychotherapy (Truant, 1998, 1999) address many of the same themes as the literature on RFT. He highlights the need for detailed assessments to ascertain suitability for psychotherapy based on numerous criteria including:

- Capacity to form a productive working relationship, containing variables including: motivation, quality of the therapeutic alliance, the patient's relational history, constructed through the lens of their object relations (Klein, 1952), as indicative of suitability
- "Supportive life circumstances" to include time, appropriate finances, work support and family support.
- "Previous positive relationships with parents, teachers, bosses and therapists" (Truant, 1999, p. 21).

[3] See section 2.5.2.3 for a detailed description of Foucault's concept of normalisation

- “Patient model factors” are considered including: introspection, psychological-mindedness and acceptance of patterns as maladaptive.
- Willingness to align to the conventions of therapeutic interventions by demonstrating a positive response to “trial interventions”: for example having “modifiable defenses” and a good response to “transference interventions” or, in CBT, testing the accessibility of automatic thoughts and the awareness and differentiation of emotions (1999).

High expectations are thus placed on this ‘ready’ subject - the ‘suitable’ patient. Truant’s description of “patient model factors” mirror those of psychological-mindedness and insight (explored in more detail below). Processes of subjectification here construct a subject who is willing to align themselves to therapeutic conventions and knowledge. David’s (1990) observation that insight in psychoanalysis became “synonymous with the willingness of a person to agree with Freudian theory” (p. 211) seems apt here.

1.7.3 Psychological Mindedness

One of the first terms to be used in this area, and originating in the literature of psychoanalytically-informed approaches, psychological mindedness (PM) has been referred to as a prerequisite for therapeutic engagement. First defined by Appelbaum (1963) as “a person’s ability to see relationships among thoughts, feelings and actions, with the goal of learning the meanings and causes of his experiences and behaviours” (p 35) this construct appears to contain elements which are cognitive, affective and motivational. It is described as the process, with ‘insight’ as the product (Appelbaum, 1973). As Hall (1992) points out, the term has historically lacked precision and is often used interchangeably with differing terms including insight, introspection and self-awareness (Hall, 1992). Conte et al (1990) define PM as being implicitly linked both to a willingness to commit to the therapeutic alliance and to a fundamental agreement with the values and norms inherent in psychotherapy (Conte et al, 1990). This requires the patient to agree to construct their difficulties within the discursive frameworks of whichever therapeutic approach may be being used to assess PM or RFT. Bourdieu’s concept of cultural capital (1986) can be seen here to encompass these requirements, in the expectation for the patient to display an understanding of the clinician’s constructions and theories of the world, with the

inherent implications for subjectivity. Deployment of clinically recognisable language, ideologies and actions thus facilitates access to a culture or group (Bourdieu, 1986) in this case access to therapeutic provision.

Ryan and Cicchetti (1985) position PM as one pre-therapy patient variable predictive of quality of the therapeutic alliance, of which other variables include: good object relations, hope for success, psychic pain and intrapsychic flexibility (Ryan and Cicchetti, 1985) and whilst many constructions of PM view it as a prerequisite for therapeutic engagement, it is also constructed as something which can be improved or developed by psychotherapy, which can enhance insight into psychological states and processes through introspection and self-monitoring (Nykličel,Majoor & Schalken, 2010). Again through processes of subjectification we can observe the construction of a self-monitoring, self-regulating, 'ready' subject via the internalization of the norms of therapy - namely introspection and self-monitoring.

Other definitions link PM directly to therapeutic suitability with Baekeland and Lundwall (1975) stating that PM "implies the patient's ability to recognise and admit psychological and interpersonal problems, to see himself in psychological terms, to use or to accept the use of psychological constructs, or to at least imagine psychological causes of his symptoms and behaviours" (p. 655). Some have constructed PM as relating to suitability for treatment relating to how much patients saw their symptoms as psychological in nature and valued psychological well-being (Rosenbaum and Horowitz, 1983). The Psychological Mindedness Assessment Procedure (PMAP), for example, is a measure which aims to assess the abilities required within analytically-oriented therapies (McCallum & Piper, 1990). PM is operationalized here as receptivity on the part of the patient, to develop insight that their difficulties are manifestations of unconscious psychic conflicts. Here internalising of the dominant knowledges of the psy-professional results in a self-disciplining subject who accepts the use of psychological constructs thus allowing difficulties to be understood within an individualising agenda.

PM has, more recently, been theorized as relating to cognitive functioning in the areas of "cognitive flexibility, sense of personal agency and inclination towards

realistic thinking" (Beitel, Ferrer and Cecero, 2004). The Balanced Index of Psychological Mindedness (Nykličel and Denollet, 2009), developed on both community and mental health patient samples, found that PM was higher in women than men, that it was lower in "poorly educated" people and "mental health patients" and that 'insight' was negatively correlated with symptoms of psychological distress (Nykličel and Denollet, 2009). These constructions overlap with the ideas mentioned in section 1.7.1 in which RFT is constructed along lines of class, education, and gender. The addition of "mental health patients" to the list of those who display low PM, constructed as a prerequisite for therapy, raises questions in relation to who therapy is for?

1.7.4 Insight

Insight, constructed as a 'product' of PM, is linked in the literature to psychosis and schizophrenia. Lack of insight into illness is listed as a characteristic feature of schizophrenia (Poletti et al, 2012), one which has a notable influence on treatment compliance and clinical outcome (Smith et al., 1999; Kamali et al., 2001). The principal themes emerging from scales and measures assessing insight in people presenting with psychosis[4] broadly reflect constructions of insight described in the literature: acceptance of mental illness, compliance with prescribed treatment and 'correct' labelling of unusual experiences as pathological (David,1990). Amador and Kronengold (2004) propose that insight on the part of the patient includes: awareness of having a mental disorder, awareness of symptoms and attribution of these symptoms to the mental disorder, awareness of the consequences of having the disorder and, thus, the need for treatment. As Moynihan (2015) summarises: these definitions comprise similar ideas around "concordance with the clinician, compliance with treatment, and constitution of self and experience as pathological" (p. 8). Beck-Sander (1998) dismantles insight as a fundamentally flawed concept, highlighting assumptions around correlations between insight and: diagnostic significance, treatment compliance, psychological well-being, prognosis and pathophysiology (Carpenter, Bartko, Carpenter & Strauss, 1976; Amador, Strauss, Yale & Gorman, 1991). She highlights the potential impact of 'promoting insight' on the self-identity of the patient resulting in 'engulfment'

[4] See Appendix C

(Lally, 1989) in which the patient's identity is reorganized around the devalued role of the psychotic patient (Beck-Sander, 1998).

Cognitive constructions of insight centre around the cognitive processes involved in patients' re-evaluation of their unusual experiences and of "their specific misinterpretations: distancing, objectivity, perspective and self-correction" (Beck, Baruch, Balter, Steer & Warman, 2004) with the Beck Cognitive Insight Scale (BCIS) evaluating "self-reflectiveness" and "overconfidence of their interpretations" on the part of the patient and suggesting further identification and correction of inaccurate beliefs and misinterpretations. Literature in this area also constructs insight as being linked to the cognitive impairment that affects 85% of people with schizophrenia (Medalia & Lim, 2004). The construction of cognitive impairment in schizophrenia as a result of the disorder is based on an assumption that it is disease processes which cause the impairment as opposed to other factors such as side effects of medication and the idea of 'chemical restraint' (Moncrieff, 2011).

1.7.5 Readiness for Change

Following the development of the Stages of Change (SOC) model, informally referred to as "readiness for change" and described by the Transtheoretical Model of Change (TTM) (Prochaska and DiClementi, 1992), research into RFT has been flooded with studies employing this framework. The TTM proposes that a particular treatment would be effective only when matched to an individual's current stage of change (Hilburger and Lam, 1999). Stages of change (SOC) occur in a series of stages including: precontemplation, contemplation, action, and maintenance (Prochaska and DiClemente, 1982). SOC and the TTM, frequently used in conjunction with motivational interviewing (MI) (Miller and Rollnick, 1991), are applied in a plethora of clinical settings and populations including substance misuse (Abellanas & McLellan 1993; Brown, Melchior, Panter, Slaughter, & Huba, 2000), health promotion (Duncan and Cribb, 1996) and offending behaviour (Casey, Day & Howells, 2005). As explicated by Casey et al (2005): the TTM has, over the past twenty years, become the most widely used model of behaviour change in the treatment of addictive and/or problem behaviours.

Whilst it is not possible within the constraints of the current study to provide an in-depth examination of how SOC and TTM are constructed it is important to note that TTM can be seen to express powerful norms about what is good or bad, healthy or unhealthy, acceptable or unacceptable behaviour (Duncan and Cribb, 1996). It could be argued that these approaches represent technologies of power (Foucault, 1968) implicit in the construction of a neoliberal subject through processes such as MI, which is used to understand the client's perspective but also to "strategically elicit language that promotes greater commitment to change from a client" (Muscat, 2005). Indeed, these models of readiness appear to provide almost a crossroads between psychological approaches, problematic behaviours and 'coercive' treatments in forensic psychiatry and the criminal justice system (Day, Tucker & Howells, 2004). For psychologists using interventions with the aim of reducing criminal recidivism risk, for example, MI has been employed to shift offenders towards a "prosocial" lifestyle, enabling prisoners to increase their readiness to change "by an average of one stage" (Anstiss, Polaschek & Wilson, 2011). Here processes of governmentality[5] can be seen in operation, as the power of the state is transmuted and supported through patterns of power-knowledge relations in the human sciences - in this case psychiatry and psychology – through their claims to expert knowledge. The power to define 'normality' and construct a 'prosocial' subject who is ready to change thus transforming unstable power relations via disciplinary technologies and self-regulatory patterns of subjectification.

1.7.6 Motivation

Motivation is also acknowledged to be an ambiguous concept (Drieschner, Lammers & van der Staak, 2004). Conceptually it is closely linked in the literature to both RFT and Stages of Change (SOC) and the Transtheoretical Model (TTM). As Krause (1966) highlights, a patient's motivation is a central factor in outcome of treatment because the psychotherapy patient "does not merely receive treatment but must actively participate in it" (p. 9). Early measures of motivation assess the patient's acceptance of the patient role, compliance with treatment and readiness to openly discuss personal matters

[5] See section 2.5.2.2 for a detailed description of Foucault's concept of governmentality.

(Krause, 1967). Foucault's concept of disciplinary power[6] (Foucault, 1966) is prescient here; namely the potential to induce a self-disciplining state in the patient through continuous observation and assessment. Processes of self-regulation and disciplinary practices thus function to construct the ready patient as a neoliberal subject who will internalise the norms of therapy. Other motivation scales address criteria such as: curiosity to understand oneself, desire to change, preparedness to make reasonable sacrifices, introspection and degree of autonomy (Keithly, Samples & Strupp, 1980; Kernberg et al, 1972; Sifneos, 1975). However, many of these criteria can be seen to be conflated with psychological well-functioning (Rosenbaum and Horowitz, 1983). Duivenvoorden (1982) demonstrated that patients considered to be motivated by their therapists were more attractive, more verbally-oriented and more insight-oriented than those who were assessed as unmotivated (Duivenvoorden, as cited in Dreischner et al, 2004). The construction of motivation as implicitly linked to the exclusion of less intelligent, less introspective or less well patients is significant in relation to how constructions of motivation or RFT may be functioning within processes of subjectification of an idealised 'ready' or 'motivated' therapeutic subject. Dreischner et al (2004) emphasise the difficulty caused by circular definitions of motivation (and related concepts), which is "inferred from the very behaviour it is assumed to predict" (p. 1119), highlighting the potential for pejorative attitudes to stem from definitions which infer motivation from behaviour; the implication being that non-engagement in treatment is seen as unwillingness of the part of the patient. "Psychotherapy thus is still, for some, the business in which the customer is always wrong. 'Insufficient treatment motivation' is the convenient accusation which conjures up ghosts of insufficient moral fiber, of weak will power, or incorrigible badness" (Hacker, 1962).

Motivation and RFT are both also linked in the literature with level of distress. This association functions in two ways: firstly through incongruence between the expectations of the patient and the expectations of the therapist and/or referrer which may be a source of distress (O'Hare, 1996) and secondly, whereby the patient is thought to have increased levels of motivation or

[6] See section 2.5.2.1 for a detailed description of Foucault's concept of disciplinary power.

readiness for change if they are experiencing high levels of distress in their current situation (Moore, Tambling & Anderson, 2013). With the reduction in psychiatric bed numbers leading to an increased level of crisis and distress required to meet thresholds for admission, it could be assumed that patients in these settings show increased 'motivation' or 'readiness' for therapy. However, high levels of distress are positioned in the literature as being both associated with increased motivation, as highlighted above, *and* as associated with decreased motivation (Knerr et al, 2011). High levels of distress are thus constructed as both necessary for RFT and as a hindrance.

1.7.7 Engagement

Frequently discussed in clinical settings, and often used synonymously with the idea of RFT, Tetley, Jinks, Huband & Howells (2011) found that "engagement" (and "disengagement") are poorly defined and frequently conflated with concepts of treatment readiness, treatment motivation, and the 'working alliance'. They suggest that readiness variables such as attitudes to treatment are likely to predict 'engagement', which they state refers to "the extent to which the client actively participates in the treatment on offer" (p 928). Highlighting that premature termination of therapy has been estimated to be as high as 82% (Ben-Porath, 2004; McMurran, Huband & Overton, 2010; Wierzliki & Pekarik, 1993) Tetley et al (2011) link low engagement in therapy to premature termination, affecting outcomes, causing services to become cost-ineffective and demoralizing staff (O'Brien, Fahmy and Singh, 2009). As we can see, engagement articulates an economic discourse relating to the impact of low engagement (or unreadiness for therapy) on outcomes and cost-efficiencies. Engagement, or RFT, is constructed here as an ontological reality, able to predict outcome within a realist biomedical framework. Scientific knowledge is privileged and deployed within the power-knowledge nexus to construct a form of 'best practice' in line with economic and biomedical discourses The clinician is thus required to construct themselves, through processes of subjectification, as aligned to clinical guidance and functioning within a 'scientist practitioner' model (Stoltenberg & Pace, 2007) to enable evidence-based interventions with demonstrable outcomes, a discursive transformation linked to economic and efficiency agendas.

Tetley et al (2011) suggest the measures of treatment engagement should assess: attendance at requisite sessions, completion of treatment, completion of between-session tasks (where appropriate), contribution to therapy sessions, to include "self-disclosure and/or other tasks or activities", and appropriate working alliance with the therapist. Again we can see here processes of subjectification constructing the 'engaged' subject in a similar way to the 'psychologically-minded' subject as one who is compliant with treatment. Again the assessment of willingness or ability to 'self-disclose' can be seen as deploying the technology of the confessional (Foucault, 1982). The requirement for a neoliberal, self-regulating subject who is able to continue to work and be productive creates subject positions in which individuals are compelled to conform. Interestingly "vocational performance" has been employed as an outcome measure of psychiatric rehabilitation (Ferdinandi, Yoottanasumpun, Pollack & Bermanzohn, 1998) whilst the development of IAPT (Increasing Access to Psychological Therapies) can be seen to be imbued with functions of governmentality through its overt link to economic outcomes.

In literature relating to mental health, persons with serious mental illness (SMI) "particularly schizophrenia" are constructed as "often difficult to engage" (Mueser, Bond, Drake & Resnick, 1998; Sainsbury Centre for Mental Health, 2001; Tait, Birchwood & Trower, 2002) with reasons being located in the person: "many are suspicious of statutory services because of their upbringing, life experiences or attitudes" (Sainsbury Centre for Mental Health, 2001, p.8), disregarding potentially coercive and abusive practices which the individual may have experienced from statutory services.
By constructing those with SMI as "difficult to engage" (or not ready for therapy) dominant discourses within the research have the potential to create barriers to this group accessing therapy as a resource. The absence of literature on RFT in inpatient settings, as we shall see in the following sections, demonstrates this exclusion of the non-conforming or 'unready' subject on a conceptual level.

1.7.8 Summary: Readiness for Therapy and Assessment

The assessment of RFT can be considered to be a technology of power in which both patient and clinician are constructed through processes of subjectification. The clinician is subject to professional discourses of evidence-

base, measurement and efficacy relating to broader economic discourses of governmentality. The therapeutic subject can likewise be constructed in differing subjectivities: patient, client, survivor according to the deployment of expert language, and overwhelmingly within a 'discourse of deficit' (Gergen, 1997). Subjectification within the assessment process can have implications for access to therapy, for example, the requirement to adhere to clinical conventions of differing therapeutic modalities in the patient's understanding and communication of their distress or else risk being labelled 'not ready'. Assessment of RFT can therefore be considered to be a technology of power in creating or limiting subject positions available through the discursive deployment of 'regimes of truth' (Foucault, 1965) via power-knowledge relations. The clinician, functioning within a realist biomedical model, thus has the power to define: 'readiness' as an object to be assessed, the therapeutic subject within the role of 'patient', what constitutes the 'ready' therapeutic subject and thus who can gain access to therapy.

1.8 Readiness for Therapy in in Adult Acute Inpatient Settings

The discussion of readiness for therapy is particularly pertinent in inpatient settings. As noted by Durrant et al (2007) "a frequent complaint by service-users of psychiatric in-patient units is the unavailability of talking therapy at precisely the time when they need to make sense of their situation". (p. 117).

1.8.1 Therapy in Inpatient Settings: Availability and Access

National Institute for Health and Care Excellence (NICE) guidance recommending at least one psychological intervention per week for inpatients (National Institute for Health and Care Excellence, 2014), Accreditation for Inpatient Mental Health Services (AIMS) recommends "Inpatients have access to specialist practitioners of psychological interventions for one half-day (four hours) per week per ward" (37.4) and that "At least one staff member linked to the ward is delivering two or more problem- specific, high intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance)" (38.8) (Accreditation for Inpatient Mental Health Services, 2010). However, Bowers et al (2006) found that 87 per cent of acute mental health wards in England had no dedicated clinical psychologist. A survey by the

Sainsbury Centre for Mental Health found that fewer than 20% of ward managers reported their ward having access to CBT (Sainsbury Centre for Mental Health, 2005). However, as pointed out in British Psychological Society (BPS) guidelines, the number of those who actually receive CBT is a fraction of this 20%, which accounts for 'access to', not 'delivery of' therapies (British Psychological Society, 2012). The NICE guidance updates for schizophrenia (2014) and depression (2009b & 2018) also highlight that psychological interventions can be started during the acute phase or after a period of crisis provided the intervention can be completed notwithstanding discharge or transfer (British Psychological Society, 2012). As discussed, due to the decreases in psychiatric bed numbers those admitted are likely to be in an increased level of crisis, having met the higher threshold for admission, suggesting that "NHS psychiatric hospitals are increasingly used to care for and contain people who are seriously mentally ill and who are considered to pose a risk to themselves or others." (Mental Health Bulletin, 2011b). Bowers et al (2005) highlight that acute inpatient care is now used by those who are most vulnerable and seriously ill , with, inpatient environments shifting towards more a custodial function and most acute wards locked (Care Quality Commission, 2010). Papoulias, Csipke, Rose , McKellar and Wykes (2014) examine the current emphasis on the ward as a temporary place for containing and stabilizing, questioning whether it can be a therapeutic space (Papoulias et al, 2014), whilst Bowers (2005) highlights broad questions about the function and purpose of acute psychiatric wards, indicating a lack of clarity and agreement on what inpatient care is for (Bowers et al., 2005). Profound differentiation in access to psychological therapies remains, with, for example, women being more likely to access psychological therapy than men (Nam et al., 2010) and black and minority ethnic groups much less likely to be referred to psychological therapies (Mind, 2013). Furthermore, due to the nature of being in an enclosed environment the client has less autonomy and no recourse to alternative resources to those offered on the ward (Warner, Mariathasan, Lawton-Smith & Samele, 2006), for example attending hearing voices network meetings. Differences in power relationships in this environment also have an impact on the construction of RFT given that the clinician has more power and control over the patient's life than at any other point in mental health services (Laugharne, Priebe, McCabe, Garland and Clifford, 2012). Decisions concerning RFT are

made on multiple levels: by referrer by psychologist at assessment, on an institutional level through choices about provision and type of psychological therapies made available or through decisions made at a research and policy level. There follows a discussion of the literature concerning RFT in adult inpatient settings.

1.8.2 Literature on Readiness for Therapy in Adult Inpatient Settings

Within the literature searches for RFT in adult inpatient settings the search terms:
(Readiness OR Preparedness) AND Therap* AND Inpatient AND Psychiatr*, returned fifty articles. The majority of these articles concerned SOC and TTM, and applied to only those patients with a 'dual diagnosis' (psychiatric disorder and substance misuse). None were found which address RFT in relation to non-comorbid mental health difficulties. Interestingly the vast majority of this literature on RFT (or SOC) and 'dual diagnosis' in inpatient settings relates to psychosis and schizophrenia rather than any affective or personality disorders. A restriction of the search terms to exclude these dually-diagnosed populations: (Readiness OR Preparedness) AND Therap* AND Inpatient AND Psychiatr* NOT Substance NOT Addict*, and filtered to include only adult populations, returned 19 articles of which 18 were screened to be of low relevance to the present research. The one relevant article: Fuller's (2013) study on psychological readiness, concerned group therapies across inpatient and outpatient settings, an area which is outside the parameters of the current study. The following discussion will therefore address hypothesized reasons for the absence of literature in this area before continuing to outline the rationale for the present study.

As discussed in section 1.4, there are multiple problems faced by and in current acute inpatient psychiatric care in the UK. In addition to the difficulties already outlined, the literature records: deficits in leadership, risk management and clinical skills (Standing Nursing and Midwifery Advisory Committee (1999) ; high levels of crisis-centred care and chaos (Sainsbury Centre for Mental Health, & Seymour, 1998). and un-therapeutic conditions, overworked staff and a climate of fear (MIND, 2004). Walton's (2000) study found a lack of therapeutic direction on acute wards with minimal activities provided, a medication-centred view of

care coupled with an avoidance of social factors in the diagnosis of mental disorders and lack of attention to patients' civil rights (Walton, 2000). Bowers et al (2005) argue that the longstanding focus on community care has led to a drift in acute inpatient care both on a policy and research level. However, inpatient beds are still a necessary part of service structures and as pointed out, no service has been able to manage without them completely (Bowers et al, 2005). The intersection between lack of research, lack of policy focus, medicalised approaches to 'treatment' and a shortage of therapeutic provision therefore appears to be integral to the dearth of literature on RFT in these settings.

1.9 Rationale

This literature review has briefly considered the multifarious discursive constructions of RFT. Investigations into RFT appear in many different guises, broadly privileging an individualised understanding of distress in adherence to biomedical understandings of mental illness. However, yet to be explored is the way this concept is constructed. This thesis therefore adopted a critical realist social constructionist[7] stance in order to enable consideration of phenomena as constructed in talk and of implications for the material realities impacted by these constructions, including lack of provision of, or access to, therapy.

As clinical psychology aims to reduce psychological distress and to enhance and promote psychological wellbeing (British Psychological Society, 2010) it is important for clinical psychologists to be aware of the potential impact of professional discourses. Clinical discourses which label someone as 'ready', or not, for therapy, have the capacity to position differentiation in access as 'common sense' rather than socially constructed, masking on-going inequalities created by service structures (Miller and McClelland, 2006). This is particularly relevant in inpatient services where there are already-noted problems around access and provision. RFT could therefore be seen as part of a power-knowledge nexus which constructs a subject who must adhere to the individualised biomedical constructions of distress.

[7] See section 2.3

Despite the dearth of literature on RFT in acute inpatient settings, it is clear that therapy does take place in these settings and that decisions about RFT will be made as part of the allocation of therapeutic resources. With these issues in mind this research seeks to address how RFT is being discursively constructed in adult inpatient settings, how it is functioning, and what the implications of these constructions are for provision of and access to therapy. By undertaking an analysis of the professional discourses of both clinical psychologists' and psychiatrists' constructions of RFT this study intends therefore to investigate discourses that may impact both patients and professionals and the implications for practice and for the subjectivity of the patients who are, or are not, referred and assessed.

A Foucauldian Discourse Analysis (FDA)[8] will facilitate this study to explore RFT as a discursively constructed entity, functioning within socio-cultural norms, with implications for the subjectivities of both clinician and patient. A critical realist social constructionist approach such as FDA can thus map discursive practices and power-knowledge structures to enable an understanding of how RFT is rendered a problematic construct in inpatient settings. This research is therefore valuable as a means of ensuring clinical psychology is able to meaningfully support those in inpatient settings who may wish to access therapeutic support, shaping practice and access to therapy.

1.10 Research Questions

How do clinicians construct their understanding of the concept of readiness for therapy?

How is the discourse around readiness for therapy functioning in inpatient services?

How does the construct of 'ready' or 'not ready' position someone in relation to inequalities in access to therapy and what are the potential consequences?

[8] See section 2.5

CHAPTER TWO: METHODOLOGY

2.1 Introduction

This chapter will outline the epistemological position and theoretical perspective of the study and how these perspectives will be used to explore the research questions. A rationale for the chosen position will be provided, followed by a discussion of the methodological approach and method employed. The procedures employed are outlined including: data collection, transcription, recruitment and participant information. This section will also address processes of ethics, data collection, analysis and reflexivity.

2.2 Methodological Rationale

The study aims to explore how clinicians working in adult acute inpatient mental health settings, primarily clinical psychologists and psychiatrists, construct the concept of readiness for therapy (RFT) and the implications for practice around provision of and access to therapy. Investigations into readiness for therapy appear in the research literature in many different guises, principally explored through realist epistemological methods with mixed findings (cf. Ogrodniczuk et al, 2009; Truant, 1999; Krause, 1956; Ryan, 2001; Heilbrun & Sullivan, 1982; Fuller, 2013). Remaining unexplored however are the ways in which this concept is constructed and the implications of the potential impact of professional discourses. This study intends therefore to investigate discourses that may impact both patients and professionals. A qualitative, social constructionist approach was used in order to enable the study's exploratory nature and to contribute to an alternative research base. Foucauldian Discourse Analysis was used to facilitate examination of how the subject is constituted through both discursive and non-discursive practices (Foucault, 1967).

2.3 Epistemology

As Harper (2011) points out, epistemological paradigms can be seen to lie on a continuum from realism to relativism. A realist epistemological position pertains

to understanding the data as a reflection of a knowable reality, a phenomenon 'which exists independently of the researcher's awareness of it' (Willig, 2013). Phenomenological approaches consider that the objective world as 'a product of human consciousness and its interpretative processes' (McHoul and Grace, 1993) they are therefore concerned with the subjective experience of the participant. The epistemological position taken in this study: social constructionism, falls at the opposite end of the spectrum to realism and would challenge assumptions of universal knowledge.

2.3.1 Social Constructionism

This study will align itself with four key assumptions of social constructionism outlined by Gergen (1985):

1. A critical stance to taken-for-granted knowledge
2. Historical and cultural specificity in relation to understandings of the world
3. Forms of knowledge are sustained over time not due to empirical validity but rather to the shift or stasis of social processes
4. Descriptions and explanations of the world themselves comprise forms of social action

Social constructionism is concerned with how knowledge is generated and views this generation as occurring primarily through social processes (Harper, 2011). The social constructionist position suggests that multiple versions of 'truth' are possible and does not privilege one version over another. Social constructionism does, however, consider how one version of truth can achieve a privileged position over others and suggests that 'human experience, including perception, is mediated historically, culturally and linguistically' (Willig, 2013). Language is important in the context of social constructionist research because, according to Willig (1999), it enables investigation of how realities and knowledge are constructed; language, rather than merely describing the world, both constructs the world as we observe it and has material consequences (Burr, 2003). The importance of language, and of historical and cultural mediations of experience and reality is central to the exploration, in this study,

of the way in which professionals construct their understandings of readiness for therapy.

2.3.2 Critical Realism

The study will take a critical-realist position. That is to say, a realist ontological stance, which assumes the existence of a material reality, but one which is epistemologically relativist in that it acknowledges that research data are not a direct reflection of 'reality' and are impacted by our context, such as our place in history, our culture and our gender, which will influence the way we talk about a subject and the categories we may apply. It could be claimed that social constructionist and critical realist positions are somewhat at odds with one another; this study, however, will align itself with the view of Sims-Schouten et al (2007) that 'critical realism combines constructionist and realist positions [and that] while meaning is made in interaction, non-discursive elements may also impact on meaning' (p.102). An analysis of how clinicians construct their understandings of readiness for therapy will therefore examine the constructive power of language and its embededness in everyday practices, whilst also allowing for the understanding of embodied and material non-discursive aspects of experience (Cromby and Nightingale, 1999).

2.4 Methodology

2.4.1 Discourse Analysis

Discourse analysis as a methodology developed within the field of social psychology in the 1970s and 1980s. Previous assumptions around discourse as a set of signs able to describe reality or label internal states, were challenged and language came to be seen as a social performance with productive potential (Willig, 2013). According to Georgaca and Avdi (2011) discourses are "*systems of meaning* that are related to the interactional and wider socio-cultural context and operate regardless of the speakers' intentions" (p. 147). Parker (1992) further elucidates discourse as a "system of statements which constructs an object" (p.5). There are two principal approaches to discourse analysis: discursive psychology (cf. Potter and Wetherell, 1995) and Foucauldian Discourse Analysis (FDA). This study will utilise FDA due to its focus on the constructive power of language and emphasis on the mediation of

power relations through discourse (Burr, 2003). The attention given in FDA to historical inquiry, power, and processes of subjectification is felt to be particularly apposite for the foci of analysis in psychological research (Arribas-Ayllon & Walkerdine, 2008). FDA also recognises that, in a social world, different constructions can result in different social power (Harper & Spellman, 2006).

2.5 Method

Informed by the thinking of Michel Foucault, FDA will be used to explore how subjects and objects are constructed through discourses and the discursive resources that are made available within a culture (Parker, 1992).

2.5.1 Foucauldian Discourse Analysis

Foucault's thinking around the 'history of systems of thought' can be seen to centre around three principal concepts: power, knowledge and discourse. In all three of these concepts Foucault moved beyond structuralist views and it is this post-structuralist theorizing upon which this research draws: instead of seeking to uncover the 'real' structures underpinning certain events or historical material; or taking the phenomenological view that 'reality' is constructed by human consciousness and our interpretations, Foucault could be seen to 'go outside' these forms of thinking (McHoul and Grace, 1993).

In order to describe the 'Foucauldian' approach to discourse analysis Foucault's conceptualisation of 'discourse' will be first be elucidated. Foucault's definition and ways of thinking about discourse render its meaning quite different to Anglo-American traditions, which typically see discourse as an illustration of the use of language. Instead Foucault views discourse as describing "rules, divisions, and systems of a particular body of knowledge" (Arribas-Ayllon & Walkerdine, 2008). It is a "system of statements which constructs an object" (Parker, 1992, p.5). Discourse is therefore, according to Foucault, closer to the concept of 'discipline' both in relation to disciplinary divisions of knowledge such as economics, medicine or psychiatry; and in relation to disciplinary practices within institutions of social control such as the prison, the school or the hospital (Arribas-Ayllon & Walkerdine, 2008). Foucault's idea of discourse "shows the

historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility)" (McHoul and Grace,1993). For example, mandating that for a patient to be considered 'ready' for therapy they must demonstrate 'psychological mindedness', or 'insight' on some level, accepting they have a mental illness and therefore adhering to a biomedical model of distress. Discourse is therefore implicated in relation to power and knowledge: in privileging certain types of knowledge, dominant discourses make available ways of being that have implications for how power is exercised.

Power, as theorised by Foucault, moves beyond the unitary conceptualisations of Marxism and structuralism (Arribas-Ayllon & Walkerdine, 2008). Foucault held that power was not simply a repressive force but productive (Oksala, 2007) and as functioning in direct relation to knowledge. Through cultural norms and scientific discourses subjects are constituted, rather than repressed, by power. Fields of knowledge and relations of power are intrinsically joined together in what Foucault referred to as power-knowledge relations (Oksala, 2007). Foucault maintained that the regulation of scientific practice is always bound to the power relations of the society in question. It is the power-knowledge nexus which is argued to be constitutive of subjects. The subject for Foucault is identified as product rather than producer, constituted via the productive functioning of power (Kendall & Wickham, 1999). The subject position thus functions within a triad of power, knowledge and the subject, and has implications for the action of an individual. Foucault described his work as a genealogy of the modern subject: "a history of how people are constructed as different types of subject – as delinquents, homosexuals, mentally ill, or, through such exclusions, as normal and healthy" (Oksala, 2007). This understanding of the subject, and the possibility of resistance, is tied to the social constructionist position of a critical stance to taken-for-granted knowledge (Gergen, 1985). When subjectivities or identities are revealed as social constructions rather than expressed as natural truths, the potential to contest or transform degrading or oppressive identities is unlocked. In FDA therefore, by understanding the positioning of subjects in relation to power and knowledge, there lies the possibility for action, for acting in an alternative way, for resistance. If power is understood relationally in this way, as constantly shifting

in relation to knowledge, discourse and the subject, resistance cannot be conceptualised as opposed to power, rather it is intrinsic to it. As Foucault emphasises “Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power (Foucault, 1978a, p.95).

FDA can be conceptualised more as a collection of methodological tools rather than a specifically defined methodology and there are varying approaches to the process (cf. Parker, 1992; Willig; 2003; Arribas-Ayllon & Walkerdine, 2008). However, Arribas-Ayllon & Walkerdine (2008) have suggested that there are three dimensions common to the production of Foucauldian-informed research: consideration of power and its functioning, an historical or ‘genealogical’ approach to current discourse and finally an analysis of the processes of subjectification (Arribas-Ayllon & Walkerdine, 2008). Foucault’s elucidation of knowledge as tied to both power and discourse, can be seen to implicate psychology as holding a role in the constitution of the social domain (Arribas-Ayllon & Walkerdine, 2008). The subject in psychology is thus shifted, from one with internal ‘truths’ to be uncovered via scientific measurements and assessment, to one who is in fact constituted by those processes and technologies of power (Foucault, 1968) intrinsic to the discipline. Subjectivities, it must be clarified, are not directly determined by discourses and Foucault specifies the element of chance inherent in the formation of subjects (Foucault, 1982).

2.5.2 Analytical Tools

“I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area” (Foucault, 1994, cited in O’Farrell, 2005, p.50). With these words of Foucault in mind this research will draw on some of Foucault’s conceptual ‘tools’, which will be elaborated on below.

2.5.2.1 Disciplinary power Foucault’s conception of disciplinary power, developed through his genealogical study in Discipline and Punish (1975), was based around Jeremy Bentham’s Panopticon. In this ideal prison design a central tower fitted with large windows looks out onto a surrounding circle of

cells in which the inmate, separated in his cell and unable to see fellow inmates, is continuously visible, unable to see where and when and if the guard is looking. By inducing this state of permanent visibility the effect of the Panopticon is to generate the internalization of a permanent self-surveillance, and thus self-disciplining, within the individual, ensuring the automatic functioning of power. The functioning of panoticism in psychiatric units also demonstrates the intrinsic relationship between knowledge and power. The continuous observation of patients facilitates assessment, the use of this knowledge then enabling the effects of power.

2.5.2.2 Governmentality: Foucault's conceptualisation of governmentality (Foucault, 1978b) operates in line with his later thoughts on power: a force which operates through power-relations, multidirectionally (as opposed to the downward oppressive force outlined in Marxism) and with a plurality of effects (Downing, 2008, p19). Foucault (1978b) articulates governmentality as a specific form of political functioning, a technology of power with the population at its center as an object of scientific knowledge and statistical measurement. It accounts for practices of self-formation, or 'technologies of the self' (Foucault, 1988) in which individuals effect, by their own means, operations on their own bodies, minds and souls, transformations by which to attain a certain state of happiness of quality of life.

In Foucault's use of the term he sought to apply the broad meaning of the word 'government'. Thus governmentality is not necessarily identified with the organs of state power, although these can be linked or implicated, but with the guiding of the behaviour of another, the conducting of their conduct (Thompson, 2003). In line with neoliberal forms of government, governmentality as a technology of the self, is closely tied to normalisation (section 2.5.2.3) and responsibilization whereby the subject is led to see social risks such as poverty, unemployment or illness, not as the responsibility of the state but as the responsibility of the individual, constructing these problems as 'self-care' (Lemke, 2001, p 201) or 'consumption' (Giesler & Veresiu, 2014).

2.5.2.3 Normalization: Scientific or medical knowledge, it was acknowledged by Foucault (1978a), are privileged forms of knowledge within our society.

Particular scientific discourses have normalizing effects as behaviours, experiences and desires are collated, measured and shaped to create a norm. According to Rose (1999) a norm is that “which is socially worthy, statistically average, scientifically healthy and personally desirable” (p. 76). Subjectification then occurs through the internalization of and adherence to these norms. By pursuing normality through adjusting and transforming our behaviour, we become individual subjects. Individuality is thus minimized by norms, which reduce subjects to a bell curve or ‘normal distribution’. Through observation and assessment the clinician thus defines both normality and abnormality through coding and classification.

2.5.2.4 Ethical Fourfold: In the second and third volumes of *The History of Sexuality (*1984a & 1984b) Foucault lays out his particular conceptualisation of ethics, traced back to antiquity. Ethics can be seen to refer to the way in which a subject of morality forms themself, acting in reference to the prescriptive elements of morality. In these later writings Foucault appeared to shift his focus from power and practices of domination towards practices of the self: modes of action that individuals exercised upon themselves (Oksala, 2007) or, in relation to ethics, the self’s relationship to itself. The Ethical Fourfold describes the modalities through which the formation of the ethical subject could be examined. It entails:

1. One’s ethical substance, ‘ontology’, the part of the self that is the principal focus of ethical behaviour.
2. The mode of subjectification ‘deontology’, the way in which the subject recognises their ethical obligations by establishing their relation to the moral code.
3. The ethical work engaged in, ‘ascetics’, via technologies of the self, in order to become an ethical subject
4. The ‘telos’ or goal of ethical activity aspired to in the ethical work of the subject. The below analysis will focus particularly on component two: the mode of subjectification.

(Foucault, 1984a & 1984b).

Foucault's concern was with the self as a problem, one that requires manipulation and production, thereby becoming a basis for ethics.

2.6 Procedure

2.6.1 Ethics

The University of East London Ethics Committee gave ethical approval for this study[9]. NHS ethical approval was not necessary due to the participants' roles as clinicians in the NHS and therefore, as specified in current guidance, were not deemed to be vulnerable. Consent was obtained from each participant pre and post interview. Confidentiality and anonymity guidelines were followed with all identifiable information changed.

2.6.2 Participants

2.6.2.1 Sample size: Ten participants were interviewed in total. This was considered to enable a range of discourses to emerge from data collection

2.6.2.2 Participant selection criteria and recruitment: The type of participants recruited was determined by the research question. It was felt that two of the professional groups: clinical psychologists and psychiatrists, working in adult inpatient services, would facilitate a representation of professionals involved in processes of referral for and assessment of RFT. Purposive sampling (Tashakkori & Teddlie, 2010) was used to recruit appropriate participants. Initial contact was made with an Acute Forum of clinical psychologists working in inpatient services within a London NHS Trust. They were sent an information letter[10] and subsequently interviews were arranged. Following each interview participants were approached for professional contacts, both psychiatrists and clinical psychologists who would meet selection criteria for interview.

2.6.2.3 Profile of participants: Of the ten participants five were female and five were male. As stipulated by the inclusion criteria, they all worked in acute adult inpatient wards in both assessment wards and treatment wards. Five participants were clinical psychologists and five were psychiatrists. Both

[9] See Appendix C
[10] See Appendix D

professional groups included participants across a number of pay bands including psychiatrists on training rotations through to service leads.

2.6.2.4 Profile of wards: Participants worked in a range of acute adult inpatient wards. including ‘assessment’ or ‘triage’ and ‘treatment’ wards. Assessment/triage wards are brief stay wards to which all patients requiring admission will go for brief assessment and treatment before being either discharged or transferred to a treatment ward (AIMS, 2010). The average length of stay on a triage ward is seven days, compared to 22 days on a standard or ‘treatment’ acute ward. About half of all admissions to a triage ward are transferred to another inpatient ward (Williams et al, 2014). ‘Long-stayers’ are defined as being admissions of more than 90 days (Smith and Chakraborty, 2012). As highlighted in chapter one, the population of acute wards has shifted, with a higher proportion of those admitted falling under the diagnostic criteria of schizophrenia/schizoaffective disorder (59%), followed by mood disorders (21%), personality disorders (12%) and organic causes/dementia (9%) (Smith and Chakraborty, 2012).

2.6.2.5 Profile of the researcher: Reflexivity and subject positioning: In line with the critical realist approach of this study the importance of reflexivity will be a key element throughout the analytic process. Haraway (1988) critiques the ‘God’s eye view’ in positivist research, arguing that it is impossible for the researcher to be positioned “outside of” the subject matter (p. 6) as their own standpoint will unavoidably shape the process of the research and its findings. Both personal and epistemological reflexivity are viewed as important (Willig, 2001). Personal reflexivity involves an acknowledgement of the two-way process in which our values, experiences, beliefs and social identities inform research and, equally, how the process of carrying out the research influences these elements and has the capacity to change us as researchers and as people. Epistemological reflexivity encourages reflection on assumptions made about the world and about knowledge, promoting consideration of the implications for the research based on these assumptions (Willig, 2001). As such, a reflective journal will be kept throughout the research process to enable reflexivity from both a personal and epistemological position and, additionally, to allow for transparency and critical self-reflection (Ortlipp, 2008).

I identify as a female, white-British, trainee clinical psychologist. My training at the University of East London has influenced my critical thinking to a great extent and has enabled me to reflect on my experiences of working in inpatient settings over the past ten years, both before and during training. I am also a psychodynamically-trained music therapist. This is important in relation to reflecting on the process of this research for two reasons. Firstly, the participants who were clinical psychologists may have positioned me, consciously or unconsciously, as an 'insider', aligned to them as a colleague (albeit a less experienced one, still in the process of training) in the same discipline; whereas the psychiatrists interviewed may not have made those same assumptions. This could have potentially the result of the clinical psychologists entering into an 'us and them' discourse when reflecting on psychiatric interventions and conventions and additionally could have created the potential for a defensive subject positioning in the psychiatrists. Moreover, as a music therapist I may also have positioned myself in the subject position of 'outsider' in relation to both professions, with music therapy viewed as less evidence-based and a less mainstream provision than clinical psychology. Secondly my training and former role as a music therapist has undoubtedly affected my opinions on therapeutic interventions which mandate a verbal engagement; linked to this my view of discourse as central to human experience may be different than a therapist trained in other, purely verbal approaches[11]

2.7 Data Collection

2.7.1 Interviews

Semi-structured interviews were employed due to the capacity for increased flexibility for both the researcher and participant, enabling the opportunity for either to pursue areas of interest arising from the talk (Smith, 1995), supporting the researcher to attain a particular level of depth not accessible by other approaches (Byrne, 2004). Semi-structured interviews were also felt to be congruent with the social constructionist approach of the study. As outlined by

[11] See Appendix E.

Silverman (1993), the interviewee is given an opportunity to construct their version of the world in the context of the posed question (Silverman, 1993).

Additionally, participants were asked to complete an element of memory work before meeting the researcher for the interview and were provided with guidance on how to carry it out[12]. Inspired by the feminist, social constructionist research method 'Memory Work' (Haug,1987; Crawford, Kippaz & Onyx,1992), memories were used as an additional prompt to help produce richer and more personalised narratives.

Each participant was asked to write two memories in preparation for the interview: one about a particular time when they had made a decision about when someone was ready for therapy and another about time when they had made the decision that someone was not ready for therapy.

The steps outlined for the participants are as follows:

1. Write 1 to 2 pages about a particular episode, action, or event

2. Write in the third person using a pseudonym.

3. Write in as much detail as possible, including even what might be considered to be trivial or inconsequential.

4. Describe the experience; do not import interpretation, explanation, or biography.

(Crawford, Kippaz & Onyx, 1992)

Use and adaptation of this element of Memory Work enabled a space for participants to focus in detail on examples of clinical decision-making around RFT. In evaluation of this process, this enabled the participants to have more time to reflect on their examples, not being 'put on the spot' during interview. Additionally in provided a space for the participants to answer in a more neutral manner a broad question, which could, therefore, be answered in a number of different directions, as opposed to being guided by more detailed interview

[12] See Appendix D

questions. Due to time constrains Memory Work was not carried out as a full methodology however, this may be a direction for any future research in this area to elicit further understandings of practice through the other phases of the methodology, for example, through focus groups.

The interview agenda[13] was constructed and agreed in collaboration with my research supervisor and was guided by a broad list of themes relevant to the literature review and research questions. Prior to the interview participants were sent information packs containing a consent form. At the beginning of each interview consent and confidentiality was discussed with participants who then signed the consent form[14] confirming that they had agreed to take part in the research, that the interview would be audio-recorded and for the material to be used in this research and for future publications. The interviews were conducted at the participants' places of work and were audio-recorded.

2.7.2 Transcription

Ten participants produced a total of 555 minutes of data (range 42-76 minutes). Interviews were recorded and were transcribed verbatim using a simplified Jefferson-lite approach (Parker, 2005) in order to capture both what is said and the way it is said.[15] Participant information was coded into number (1,2,3) sex (M/F) and profession (CP- Clinical Psychologist or P - Psychiatrist), for example: P1MCP, in order to ensure confidentiality and anonymity.

2.7.3 Extracts

Extracts from participants' interviews will be employed to exemplify the discursive sites. Using extracts as a foundation for analysis has been recommended as an essential benchmark in qualitative research, enabling contextualisation of the data, "sensitivity to context" (Yardley, 2008), rigour and transparency.

2.8 Analysis

[13] See Appendix F
[14] See Appendix G
[15] See Appendix H

As there is no one specified way of carrying out an FDA, the analysis of the data was carried out using a synthesis of steps adapted from Arribas-Ayllon and Walkerdine's (2008) discussion of how to complete an FDA, and Willig's six-stage process (2001) and employing Adams' (2016) set of flexible guidelines for the analysis of data, subjectivity and practices, elucidated below.

The interview recordings were listened to multiple times during the process of transcription, facilitating immersion in the data. The transcribed interviews were then re-read whilst listening to the interview recordings, enabling the researcher to check for accuracy and to engage in a reflexive process with the data. This was enabled through use of a reflexive journal to note any points of interest at this stage.

Analysis of the data was carried out by engaging with questions asked of the data in relation to theoretical concepts outlined by Foucault, analytic foci, which formed a number of stages as described by Arribas-Ayllon and Walkerdine (2008), Willig (2001) and Adams (2016):

1. What is the object being constructed in the talk?
2. How is the object being constructed in the talk?
3. What is the function of this construction?
4. What subject positions are being made available?
5. What are the processes of subjectification?
6. What are the technologies deployed in the talk, and what are the implications for social practice?[16]

(Adams, 2016).

A process of mapping the various constructions of discursive objects was then carried out, for example: readiness as rational, resourced, stabilized; therapy as long/continuous/a difficult process; clinician as ethical/adaptor/expert. This facilitated an examination of the ways in which the participants constructed their understandings of RFT. The next five stages were then used on the data in line with the discursive constructions of the objects identified. The process of writing

[16] See Appendix I for a detailed explanation of these steps and analytic foci.

the analysis was the final stage, wherein certain extracts were chosen which were seen to answer the research questions. The analysis chapter therefore emphasises attention to the ways in which the participants constructed their understanding of: the 'ready' therapeutic subject, their practice, and themselves as clinicians in relation to the macrostructures they are working within. This approach was intended to facilitate an examination of implications for subjectivities, practice and access in relation to RFT.

An example of the main analytic steps will be provided herein, drawing on material relating to appendix K. The full analysis relating to this extract and how it is integrated into the overall analysis is to be found in section 3.2.2, extract 15.

1. **What is the object being constructed in the talk?:** Unreadiness, in the extract in appendix K, is the object being constructed in the talk.
2. **How is the object being constructed and problematised?:** Unreadiness is constructed in this extracts as "passive aggressive", "putting questions back onto" the participant, as "hostile" as "a manic edge", as "less amenable" and as a "defensive reaction". Unreadiness is problematized, as it is constructed via the power-knowledge nexus, as a barrier to therapy. The discursive object, here unreadiness, can be seen as a product of the intersection of alternate discourses in which the patient's action of "putting questions back onto" the psychologist could have been perceived, in an alternative discursive construction, as an act of resistance rather than as "passive aggression". The power-knowledge relations of the therapeutic interaction are thus revealed in this extract: the psychologist holds expert knowledge which intersects with the power to make the decision of readiness for, and therefore access to, therapy.
3. **Functionality of the construction:** The functionality of these different constructions of the discursive object, enables the psychologist to manage her resources. The construction of unreadiness is problematized here as it is used as a label for those who may attempt to hold agency in the assessment space, who may wish to resist being positioned as client or analysand.
4. **Identification of discursive subjects:** the discursive subject being constructed in this extract is that of the unready patient. The clinician is

constructing a ‘ready’ subject who will conform to the norms of therapy, and “engage”, as opposed to one who is resisting the subject position of ‘patient’, ‘client’ or ‘analysand’.

5. **Processes of subjectification:** these processes result in a subject whose subjectivity is constructed through the lens of observation, which results in judgements being made concerning ‘readiness’. The unready subject is one who is labelled within a biomedical discourse as a subject who has a “manic edge” and whose attempts at occupying a different subject position - are labelled as “resistance”. This results in a subject who, should they wish to access therapy, must occupy the position of the “ready” patient, one who is “less unwell” and more “amenable”.
6. **Technologies of power and implications for social practice:** the technologies of power at play here are disciplinary power: centered around surveillance, through observations of “presentation” on the ward and assessment of “engagement” and normalisation through the requirement for adherence to constructions of the “ready subject” in order to access therapy. We can also observe the interdependence of power and resistance, whereby the attempt to resist the pathologised subject position of unreadiness due to “defence mechanisms” is constructed as “hostile”, “passive aggressive” and ultimately “unready”. Here the process of analytic control on the part of the psychologist can be seen as a technology of power which facilitates the psychologist to position herself as an ethical practitioner and to manage her resources.

The final stage of analysis for this example can be seen in section 3.2.2, extract 15, whereby the analytic stages are integrated into the overall analysis.

CHAPTER THREE: ANALYSIS

This chapter will review the analytic approach and structure before elaborating upon the central findings of the analysis in relation to the research questions. From a critical realist social constructionist stance, a Foucauldian Discourse Analysis (FDA) was used due to its focus on the constructive power of language and emphasis on the mediation of power relations through discourse (Burr, 2003) thus enabling an exploration of the differing forms of social power stemming from these constructions (Harper and Spellman, 2006). As highlighted by Haraway (1988), Willig (2013) and others, it is not possible for a researcher to position themselves outside of the subject matter, it is timely therefore, to note that my analysis, whilst methodologically rigourous, is just one way of constructing many possible readings of the data, the whole process of analysis being situated in relation to my own historical and cultural context (Van Dijk, 2011). It is, in itself, a discursive construction, which, through my own positioning, constructs knowledge (Willig, 2013).

The structure of this analysis centers on clinicians' constructions of the ideal 'ready' subject, their constructions of unreadiness as a tool for supporting the expert position, and their constructions of their identity as an ethical subject. Analysis was carried out using the methodology described in the previous section. Each extract[17] was considered in relation to:

- What objects were constructed in the talk and the functionality of these constructions.
- Subject positions constructed by various discourses and the implication for subjectivity.
- Technologies of power utilized and the associated effects.

3.1 Clinicians' Constructions of the Ideal 'Ready' Therapeutic Subject

This section will demonstrate the multitude of ways the participants constructed the subject who is 'ready' for therapy. Discourses of rationality, displayed by the subject via psychological-mindedness or insight, function alongside discourses

[17] See Appendix J for an example of an annotated extract.

of personal resources such as intelligence, verbal fluency and emotional strength to construct a 'ready' subject who fulfills neoliberal values. These extracts highlight the effects of normalization as a process of subjectification and the technologies of power used to construct an idealised therapeutic subject who, whilst ready for therapy, does not and cannot exist on the ward.

3.1.1 Readiness and the Ideal Therapeutic Subject

"Psy-function" (Foucault, 1973): a shifting area of knowledge and power over the mind, including psychoanalysis, psychology, psychiatry, psychotherapy, psycho-pharmacology, social psychology and criminology. Their function in sites of discipline: schools, military, prisons, hospitals, and industry (Foucault, 2006) acts via disciplinary power, which aims at restoring the efficiency of the individual and collective performance. Madness is seen, in this context, as a lack of efficiency or a waste of energy on the part of the patient (Leoni, 2013). These technologies function on a broad spectrum, from disciplining practices on inpatient wards, to the neo-liberal, self-disciplining technologies of psy-enterprise: self-help books, agony-aunt columns in magazines and newspapers, life-coaching and the current popularity of mindfulness (Binkley, 2011). The aim of these technologies is to construct a neoliberal subject who is capable of self-regulation in order to function successfully, work productively and remain free from interference or intervention from the state - the epitome of success according to neoliberal governments. Participants constructed the 'ready' therapeutic subject as a 'rational' unitary subject (Henriques et al, 1998a) resourced with multiple abilities or traits.

3.1.1.1 Readiness as rationality: Rationality was constructed by the clinicians through the use of various discourses including primarily 'insight' and 'psychological-mindedness'.

Extract: 1

> **P10FP:…***In the ward round, for the first week she would not engage at all. She would come and say "I don't have a diagnosis of bipolar disorder, I haven't taken an overdose, I had no intention to die and I need to be out of the hospital". And she was quite firm and quite came across like*

somebody who knew what she was saying and looked like she had insight. But the way she was minimizing the risk of the episode that had happened and refusing to recollect the events of what happened kind of left everybody with a sense of anxiety and (.) puzzling. What, what, what is this about? […] She was not communicating, she didn't have insight and maybe, we thought, she is so disturbed with everything that is going on that she would not be able to engage with psychology the way it should. (516-518).

In this extract we can observe the construction of a subject who is considered 'ready' for therapy as one who demonstrates their 'insight' by accepting their diagnosis, and therefore taking a 'rational' approach to their own distress. As argued by Foucault in Madness and Civilization, the traditional accounts of the 'recognition' of madness as illness, frame this event as a humane 'liberation' of the mad. Foucault asserts this as a myth, beneath which lies a series of technologies organizing the world of psychiatry, the asylum and methods of cure, according to fear, confinement and moral condemnation, the same principles that had been prevalent in the classical age (Oksala, 2007). The construction of insight here echoes those found in the literature: willingness to label experiences as pathological, acceptance of mental illness and agreement with treatment (David, 1990).

In the next extract 'insight' can be seen functioning as a technology of power (Foucault, 1975).

Extract: 2

P6FP:…*We were doing a lot of insight referring. When someone…*

RR *How do you mean, insight referring?*

P6 *So, like if someone really didn't have any insight into their illness but was doing really well and we thought that maybe if we made a start while they were on a treatment ward*

RR *Mmmhmm?*

P6 *And that could facilitate further their input in terms of insight into their illness in the community that would be beneficial. But it turns out that*

> *most of our patients didn't have any insight and so the referrals that we were making were too many and so they, the psy, the trainee psychologist set up a group focusing on insight on the wards.* (134-144).

Participant six aligns the aims of psychological therapeutic intervention with psychiatry and the medical model, viewing madness as 'illness', into which the patient must have 'insight'. Psychology as the 'facilitator' of insight in which therapy is employed as a technology of power, and psychiatry as the 'insight referrer' are engaged in a process of subjectification in which expert knowledge is deployed within the power-knowledge nexus whereby the patient could be "facilitated further…in terms of insight into their illness in the community". The implications around liberty as linked to "the community" and 'insight' as acceptance of mental illness are palpable. In order to function in 'the community', in society outside of the ward the subject must be form themselves as a neoliberal subject with 'insight'. In this context, human capital is waiting to be restored, here by the provision of "groups, focusing on insight on the wards" with insight presented as something that can be moulded and cultivated or encouraged, an object of intervention by professionals. The description by participant six: "it turns out that most of our patients didn't have any insight" also demonstrates the incompatibility with this concept on the ward, where people are in crisis. It could be argued that if the patient had adhered more to professionals' view of their experience, they would have been less likely to end up on the ward in the first place. Processes of normalisation thus function here through the internalization of and adherence to the norms required of the rational 'ready' therapeutic subject who is able to cultivate 'insight' in order to be discharged and function in the 'community'.

Extract: 3

> **P1MCP:…***I think there's a lot of expectation ((2)) certainly has been, and that's what this psychological mindedness thing for example, that we (.) we do our thing, and if you can adapt to that then you're in (.) and if you can't adapt to that then you're out. (.) And I just don't think*

that's reasonable I think it should be us that adapt. Now of course there's some people, there still has to be a line.

RR *Mmmhmm?*

P1 *Because there's some people where actually (.) you know, I mean if you're going to sit with somebody hour on hour and they cannot speak to you well then that's probably not going to get you anywhere. Or if, you know, somebody really really is not (.) able to have a conversation with you which is about anything other than how everything is other people's fault.* (623-639).

This extract demonstrates a counter-discourse where the psychologist counters expectations of 'psychological-mindedness' and ability to adapt to "our thing" with his own view that "I think it should be us that adapt". The majority of the participants' descriptions of therapy (to be addressed in section 3.3.2) construct it as static and model-based, unable to be adjusted or repositioned as it would then no longer adhere to discourses of 'evidence-based-practice' or follow NICE Guidelines. Therapy and the clinician are therefore constructed as holding themselves still, unable to respond to a subject who does not fit in to the therapeutic structure. This counter-discourse, constructed by participant one, highlights possibilities for changing practice whereby instead of expecting the patient to shift and adapt to the norms of therapy, the therapist occupies the subject position 'adaptor' and therapy is constructed as an object which can move and change in response to distress. However, even this counter-discourse has a limit: "there still has to be a line". This 'line' is discursively dually constructed as the capacity to speak to the psychologist and the ability to take responsibility and "have a conversation which is about anything other than how everything is other people's fault". The intimation by the psychologist of the necessity to take personal responsibility is again a requirement for a subject who accepts they are 'ill', whose distress is not "other people's fault". A discourse of 'responsibilization' could be seen to be functioning here, whereby the construction of distress is internalised and inextricably linked to neo-liberal discourses of individualization and 'responsibilization' (Rose, 1999) leading the subject to construct their experiences of, for example, poverty, unemployment or illness as their responsibility, constructing the solution to these problems as 'self-care' as opposed to the responsibility of the state (Lemke, 2001). The

'vulnerability-stress' model is also implied here in which biological vulnerability is impacted on by stress. As Boyle (2002) points out, this model maintains the primacy of biology, by making it look as if the 'stress' of the model consists of ordinary stresses which most of us would cope with, but which overwhelm only 'vulnerable' people. (Boyle, 2002); thus implying individual vulnerability and creating a thinly veiled biomedical explanation (Pilgrim, 2002). If the subject can take responsibility for their role in their distress, responsibility for their vulnerability, as opposed to other people's "fault", they can then "get somewhere" through talking to the psychologist and making changes through this technology of the self (Foucault, 1984a & 1984b).

Not only was readiness constructed by the participants as requiring a rational subject but madness or "thought disorder" was closely linked to unreadiness and seen as "polluting" the therapeutic interaction.

Extract: 4

P9MCP:…*I don't know how confident I would feel that I'm doing something useful for someone with a thought disorder. Erm, and if someone is unable to kind of communicate with me in those sessions then I feel like there's not much scope for helping them.*

RR *Mmm.*

P9 *So it's if, when something pollutes the interaction enough might be a problem. Naturally*

RR *By polluting do you mean: the thought disorder or…?*

P9 *Yeah, a thought disorder, or thinking quite concretely. And someone who struggles to reflect or see that they have an opinion on something and there are different perspectives of that same thing. (735-746).*

The construction of thought disorder as something that "pollutes the interaction" by the clinical psychologist here is a powerful metaphor, a pollutant being associated with disgust, to be avoided and expelled. This construction of thought disorder resonates strongly with Foucault's descriptions of the shift in understanding of and treatment of madness in the mid-17th century falling outside the spectrum of what was considered human and linked to the need for

confinement. If participant nine considers thought disorder as “polluting the interaction” and consequently does not know “how confident” they’d feel “doing something useful for someone with a thought disorder” this positions the subject as someone who is to be confined, not treated (or at least not treated with therapy), and as a threat to rationality. Pollution is a construct strongly linked to feelings of disgust which are, in themselves, socially constructed and differ widely from culture to culture, with representational discourses, in this case around “thought-disorder” as “polluting” clearly playing a part in transmitting disciplinary practices. Again it is the clinician, within the power-knowledge nexus, who defines what is rational and what might be “thought-disordered” and “polluting” to the interaction. And again the paradox present in this construction can be seen: the ‘ready’ therapeutic subject constructed by the clinician cannot, therefore, be one who is “mad”, who is an inpatient on the ward.

By drawing on a discourse of ‘rationality’ the participants are enacting power-knowledge relations in order to construct the subject *they* need to be ‘ready’ to access therapy. It is the professional who defines what is rational and what isn’t. The language of psychiatry (and psychology) thus functioning as Foucault outlined in Madness and Civilization “as a monologue of reason about madness” (Foucault, 1965). In these extracts the ‘ready’ subject is constructed as rational; a subject who is ‘psychologically-minded’ and with ‘insight; a responsibilized, verbal subject who can sit with the psychologist for an hour and have a conversation about “anything other than how everything is other people’s fault”. The paradox of these prerequisites of ‘readiness’ for therapy constructed by the participants is created by the environment in which they are situated: the inpatient ward, where traditionally the subject occupying this space would have been expected to be irrational, expected to be mad, the very reason they occupy that space being madness.

3.1.1.2 Readiness as resourced: Another way in which the participants constructed the subject who is ready for therapy centred on a subject who is resourced: with intelligence; verbal fluency; capacity to understand the significance of meeting with the psychologist; ability to pick up on the social and clinical conventions of the session; abilities to talk psychologically, to build a

rapport, to reflect, to take challenge or probing and emotional strength enough to complete the conversation.

Extract: 5

> **P1MCP:…***I think based on the fact that he's, you know, he's a bright guy who kind of, verbally can be very fluent and very agile erm, and so in a way you'd kind of think: here's a chap who should be seeing a psychologist.* (146-148).

Extract: 6

> **P4MCP:…***I do think there is, um, a kind of ((2)) some real basic things like the capacity to understand (.) what is being said […] to use language, to be able to reason, to understand the significance of meeting (.) with the psychologist, what it might mean. You know someone might never have seen a psychologist to actually sort of pick up on, the (()) you know, what the social conventions, the sort of clinical conventions quickly. I mean socialised to it. Yeah. So I mean that, all in itself, that, that, that touches on certain prerequisites.* (566-578).

A subject who is able to pick up on the "clinical conventions" quickly indicates processes of normalisation whereby the subject not only internalises the truths and norms of psychiatry and psychology, but is also able to demonstrate this "cultural capital" (Bourdieu, 1986) in order to access therapy. RFT is thus assessed by the clinician, based on their prospective patient being able to form themselves as a neoliberal subject, able to self-govern through consumption of the 'new technologies of citizenship' (Rose, 1992) such as psychology, psychotherapy.

In an earlier statement from extract three *"if you're going to sit with somebody for an hour and they cannot speak to you well then that's probably not going to get you anywhere"* (P1MCP) the construction of the 'ready' subject also includes the capability and motivation to use language. Psychology as a 'talking therapy', a term with its roots in Freud's 'talking cure', is inherently dependent

on language, which is seen by classical metaphysics as an attribute specific to mankind and what it means to be human. The ability to convey verbal accounts of distress to the clinician thus constructs a subject who again fulfills a construction of a unitary subject with a core inner self which can be accessed or not depending on their ability to speak to the psychologist.

In using the phrase “socialised to it” in relation to the patient being able to “pick up on the social conventions, the clinical conventions” the psychologist seems to be referencing a routine practice within Cognitive Behavioural Therapy (CBT). In this context CBT presupposes the existence of a “verbally fluent and agile” individual with an internal world that can be accurately communicated to another through speech (Newnes, 2011 p.217). Situated in alliance with the biomedical model CBT can be seen as a regulatory practice operating at a micro level, constructing a ‘ready’ subject who is “socialized” to engage in therapy by locating their problems on an individual, internal level and concurring with assumptions of individual pathology that need addressing (Boyle, 2011).

Extract: 7

P5FP:…*And then I guess, look for those first signs that somebody may be, may have the right ability to pay attention and concentrate, may be able to talk, may be able to think emotionally, talk psychologically, may be emotionally strong enough to, to erm, to com-complete the conversation and erm, and be interested in engaging in it.*

RR *Mmm*

P5 *Erm, so it, I think it’s a, an on-going thing and as you get to know someone better ((2)), particularly I guess seeing someone, everybody weekly, those people who engage in a conversation and are able to build a rapport and (.) reflect, who are able to erm (.) be robust and erm take feedback, or challenge or probing.* (447-459).

Throughout the data the participants construct an ideal therapeutic subject who is, in many ways, like them; expecting the patient to mould themselves into a similarity of the therapist and move towards conforming to the construction of a

white, middle-class, neoliberal subject in order to access therapy: verbally articulate, intelligent (or educated), someone emotionally strong and robust and able to regulate their own emotions. These constructions mirror findings in the literature confirming biases around race, social class and gender in diagnosis, rating level of adjustment, description of personality traits and psychiatric symptoms and referral to psychotherapy (Garb, 2006).

These requirements of RFT are paradoxical in the construction of an ideal subject who, in the context of the ward, is never going to meet these criteria: if the subject possessed all these resources and capabilities it is highly unlikely that they would come to find themselves on a psychiatric ward. To interrogate this idea further, Smail (2011) elucidates how working in the NHS, a publicly-funded institution, with people whose lack of resources results in reduced possibilities for arranging their lives, lays bare the illusion that 'choice' and 'will power' are innate potentialities. Rather, they are the result of material advantage (Smail, 2011). Additionally there is a trap of exclusion: if the patient is, due to being deemed 'not ready', denied access to those transforming technologies of the self, i.e. therapy, how can they be expected to transform themselves into the desired neoliberal, self-regulating subject? They are seemingly left to other technologies present on the ward: those of observation, self-surveillance and medication.

3.1.2 'Stabilization' and the Goldilocks Paradox

Participants constructed readiness with contradictory expectations: stabilized but still on the ward, not too early, not too late; not in crisis but not too much after a crisis with the risk that they would have "sealed over"; a subject who is able to be vulnerable yet robust at the same time, thus creating a paradox of readiness in which the subject who is a patient on an inpatient ward cannot be considered 'ready' due to timing, location and requirements for mutually exclusive internal states.

Extract: 8

> **P8FP:…***Yeah, I think, for our patients it would be: have they, (.) has their mental state changed from acutely disturbed and agitated to slightly calmer and with some rationality in their thinking.* (398-401).

Extract: 9

> **P9MCP:…***So sometimes people are not ready for therapy because they don't, they don't want to face (.) erm that it's too difficult for them to talk about now, or too scary to face, erm you know changing their behaviour so it's too early in some ways. But then sometimes it's kind of that it's too late actually they've kind of sealed over, and they don't, so you've kind of missed the window […] And they need a, and it's recognised they need a period of stability to get the most from that, probably, and that kind of lends itself to readiness for therapy doesn't it? So I, I kind of have the view actually that (.) when someone's in crisis either it is the worst time because their life's too chaotic, things are all up in the air, and they can't, they don't have the headspace erm, to make sense of what's going on, to focus on what you're saying. There's too much threat at that moment for them to reflect and that does and I've got first-hand experience of watching someone have that experience. It's very difficult to help them. The flip side of that is sometimes they've been in a crisis the absolute perfect moment because they haven't sealed over, they're willing to talk about it and they're motivated to do something about it because things are at their worst. So sometimes I think it is actually the best moment. And it's not a difficult decision to decide which one it is. It's obvious.* (699-703 & 892-916).

In these extracts a 'stabilization' discourse can be seen, where psychology is constructed by participant five as something that needs "a period of stability" as "there's too much threat at that moment for them to reflect". Positioning problems to be addressed in therapy as in the past and to be reflected on after a "period of stability" can be seen in the context of the 'safety behaviours' outlined by Boyle (2011) in which clinical psychology and psychiatry partly

acknowledge the causal role of social situations and life experiences in distress but simultaneously minimize their impact by, for example, placing the experience in the past when they can “reflect” after a “period of stability”, thus enabling the impact of context to be obscured. Assumptions are also made in this construction that people will be discharged into a stable environment (the “threat” will have passed) conducive to the reflection needed to engage in therapy, and one in which the problems which led to admissions have resolved. In the context of how acute services are currently structured and the brevity of admissions, this is unlikely. Participant nine also outlines a position where he is making a decision concerning RFT based on whether the crisis that the person is experiencing makes it the “worst time” for therapy or the “best time”, emphasizing the role of “motivation” and echoing unclear findings in the literature around the role of distress in RFT (Schneider & Klauer, 2001; Derisley & Reynolds, 2000; Moore, Tambling & Anderson, 2013). The ‘ready’ therapeutic subject is therefore constructed as needing to be able to be peturbated in order to change, again within a paradoxical discourse of stabilization. This positioning reflects discourse in the literature which highlights the requirement for patients to live a ‘suspended life’ in institutional settings (such as forensic units) which instill a ‘regime of forgetting’ where past experiences are viewed as irrelevant to ‘stabilization’ and experience is recoded into psychiatric discourse (Brown & Reavy, 2016).

Participant eight constructed psychology as something which can be accessed when the patient’s “mental state” has changed from being “acutely disturbed and agitated to “slightly calmer”. It is not discussed by the participants how these changes might be effected, other than to indicate that it is not via therapy. Common practices in the context of acute inpatient psychiatry might lead us to surmise that involved in this stabilization discourse are implicated practices around medication. Additionally ward practices of ‘observation’ (to be addressed in section 3.2.1) function to generate a normalizing environment in which technologies of the self can flourish.

In relation to disciplining practices, the stabilization discourse can be understood in this context as a means of control: the patient, through processes of subjectification, being expected to form themselves as an entity who will

occupy an idealised position of not too early or too late, not too scared but not sealed over. This stabilization discourse also potentiates a means of denying the patient access to therapy due to the fact they are ‘in crisis’ and therefore ‘not ready’ However, as described in this extract it is not as simple as denying access to those in crisis but more creating such a narrow window of possibility that very few patients will be able to access therapy on a ward, thus enabling the psychologists to manage their resources.

Extract: 10

> **P6FP:…***Erm ((4)) I guess how much they were willing to think about stuff. Yeah, I think (.) erm (.) how vulnerable they were willing to allow themselves to be and how robust they were to manage that as well.* (349-351).

Participant six describes a ‘ready’ subject who is “vulnerable” and is yet “robust” at the same time. Again this discursive construction functions to position a subject who must occupy a very precisely delineated position that is just right. In order to access therapy, therefore, the ‘ready’ subject must not only occupy a position in time and space, they must be ‘willing’ to allow themselves to occupy contrasting internal states in a delicate balance in order to ‘manage’ therapy.

In summary, this section has analysed the data by attending to constructs around the various constructions of “readiness” as relating to rationality, resources, as being “polluted” by madness and as requiring a “stabilized” position, which is access through paradoxical requirements which cannot be met whilst the subject is an inpatient on the ward. Within the power-knowledge nexus, participants constructing an ideal, neoliberal subject who, internalizing the objects, truths and norms of psychiatry and psychology can then be moulded into an object of intervention by professionals: they are ‘ready’ for therapy. Therapy and the ‘ready’ therapeutic subject are positioned by the participants as reason whilst the space they occupy - a state of madness in a psychiatric ward - is positioned as unreason. Participants responses to these dichotomies, by engaging in disciplining practices, will be attended to in the following section 3.2.

3.2 Disciplining Practices: Clinician's Constructions of Unreadiness as a Tool for Supporting the Expert Position.

This section will draw upon two common threads in clinicians' construction of readiness as a tool for supporting the expert position: constructions of 'presentation' on the ward as enabling deployment of power at the level of surveillance; and negotiations of subjectivity and resistance within the ward environment. These constructions will be linked to the processes of disciplinary and pastoral power as mechanisms of subjectification which aim to construct a rational subject.

3.2.1 "Presentation" on the Ward

Extract: 11

> **P3FCP:…***But if someone can't kind of, really have any sort of meaningful conversation, then it is obviously very hard to do an assessment. So if someone's very thought-disordered or if they're chaotic or if someone's a bit manic and they're sort of up and down out of the chair and in and out of the room, then you know, then you just think well actually let's just wait, there's just no point so, yeah, more how they present on the ward really would, kind of, negate me meeting with them. Yeah.* (345-351).

Observation or the concept of the 'gaze' (Foucault, 1963) is relevant here and can be described as a disciplinary technology in which the professional disciplines themself and others through coding behaviour. In observing "how they present on the ward" processes of subjectification are functioning to construct both the clinician as observer and patient as observed. Disciplinary technologies of surveillance, as explicated in Foucault's depiction of the Panopticon, here demonstrate the functioning of power-knowledge relations on the ward. What constitutes a "meaningful conversation" is decided by the psychologist through normalising technologies of observation and assessment. The clinician thus defines both normality and abnormality through coding and classification. As Newnes (2011) notes: clinical psychologists, as the servants

of psychiatry, “perform a powerful social function. The are the guardians of what is to be considered normal” (Newnes, 2011). The patient must then internalise a permanent self-surveillance, and thus self-disciplining in order to constitute themselves in relation to norms expected of the ‘ready’ for therapy subject.

Extract: 12

P2MCP:…*So it’s the kind of way some people might present on the ward (()) and you really think: is this the right thing at this time, so…*

RR *Mmmhmm. So what kind of things would that be?*

P2 *Erm, I guess, you know, what like we’ve, some people who might be quite sort of delusional. Um and might be, you know, confronting anyone that walks past them, and all of the content of their speech is linked um linked to those sort of delusions and there isn’t really any capacity to sort of have any other sort of conversation* .(447-461).

In this extract the clinician constructs the ‘unready’ patient as a subject who does not have the “capacity to sort of have any other sort of conversation”. “Delusions” are categorized as pathological and thus become a barrier to accessing therapy, silencing the experience of the patient, who must adhere to expected ‘norms’ in order to access therapy. The power relations here are clear: the psychologist positioned as ‘expert’ deploying knowledge which constructs what content is valid for discussion in therapy. According to Foucault (1982), expert knowledges can be considered to define which behaviours are normal, acceptable or deviant. Expert knowledges are underpinned by scientific truths which function to define norms; a set of socially accepted behaviours. Deviation from these norms are used to alert us to ‘dysfunction’ or ‘pathology’ such as ‘delusions’. Through the disciplining technology of surveillance of ‘presentation’ on the ward the clinician constructs themselves, through processes of subjectification as ‘expert’. The patient’s subjectification as ‘unready’ supports this position with the problem located internally to them rather than in the therapy, for which they are ‘unready’.

Extract: 13

> **P6FP:…***Erm ((5)) so the lady that I referred who I thought was ready, it was in a ward-round setting and I remember feeling quite, quite, I mean ward rounds are a quite difficult set-up, erm (.) and we were asking patients to talk about lots of stuff in a, in a packed room sometimes of lots of unfamiliar faces.* (39-43).

In this extract ward round practices can be seen functioning as a technology of power. Patients are expected to adhere to conventions of the psy-complex. In this case talking about personal information in a "packed room of unfamiliar faces". This discourse of 'ability/willingness to discuss personal matters openly' can be seen to be to normalize this expectation in the context of inpatient settings, positioning the clinicians as 'experts' observing and assessing the patient in ward round, demarcating power-knowledge relations. In this 'technology of citizenship' (Rose, 1990) the subject is expected to lay bare their inner self or soul to a professional thus enabling the idea of the confessional or of pastoral power to function freely (Dreyfus & Rabinow, 2014).

Foucault (1982) asserts that individualizing power finds its modern-day manifestation in pastoral power, a process of promoting the transformation of the subjectivity of others. Once found solely within the church and now found in a plethora of secularized contexts, salvation is offered by taking care of an individual's health and well-being. Intrinsic to pastoral power is the technology of the confessional. Pastoral power "cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it" (Foucault, 1982, p. 783). Thus the cost of care of the 'soul' is confession of one's innermost thoughts and feelings. (Foucault, 1982).

In the above three extracts what is being described appears to be the 'rules of the game' in relation to observation of 'presentation' on the ward and decisions around readiness for therapy. Below the participants construct what happens when someone choses not to play the game, to not talk in ward round or to not talk in the expected way in therapy. These opportunities for resistance will be explored in the following section as well as the results of resistance in these contexts.

3.2.2 Unreadiness and Resistance

Extract: 14

> **P9MCP:…***When someone is psychotic and aggressive to their family and blame the family for many of the things that are going on, and we feel that that's not based in reality. I mean it's quite difficult to say, but. And they feel they've been locked up totally against their will, that they don't have a problem of any sorts, whether it's anxiety or. Their problem is their family, are their problem. Then it's very difficult for us to have a collaborative goal.* (1032-1038).

Here expert knowledge is deployed through a biomedical discourse to construct what is considered 'reality'. If the patient attempts to resist these biomedical discourses by, for example, asserting that "their family are their problem" they are labelled as "psychotic" and "aggressive". These discourses lie in direct relation to how therapy is being constructed and what is appropriate therapy. The construction of the "collaborative goal" which, in cognitive behavioural therapy, is seen as a primary agent of change, is of interest in relation to the subjectification of the unready patient. "Collaborative empiricism" is used to "uncover" patients' automatic thoughts and underlying beliefs (Dattilio & Hanna, 2012) with the patient required to recognise and modify their "faulty cognitions". These therapeutic technologies of power construct the client as a neo-liberal subject who should be able to self-regulate. As Smail (2011) articulates: "psychological distress arises not from the *injuries inflicted by a material social environment,* but from the *desires and fantasies* (and more recently, from the *faulty cognitions*) of individuals themselves" (p. 233). Psychology is thus complicit in disciplining technologies, which create neo-liberal subjects and maintain the functioning of society. If the patient wants access to therapy they must be able to create a "collaborative goal" with the psychologist but seemingly one which must based on the psychologists' and the teams' version of reality in which the patient is "psychotic" and unwell thus locating their distress internally, rather than in the family or any other factors such as poverty, abuse or inequality. Power-knowledge relations function here result in the patient then

being denied therapy as they are resisting medicalised discourses, blaming something outside themselves.

Extract: 15

> **P3FCP:…***And there was a guy who was quite sort of passive aggressive. […] So when I asked him a question he'd sort of put it back on me, like: "Well, what do you think? I mean what do you expect?" And erm, and then was going "Mmmm, yeah" you know, sort of looking at me you know in a really sarcastic, sort of, this really sarcastic smile on his face, "that's an interesting question" and he just […] so just his manner and I, I guess that's another example of how, you know, someone I wouldn't see because they just weren't able to, sort of engage, it's more about his presentation at that point in time and I don't know whether, when he's less unwell, you know, he'd be more amenable, but that was kind of I suppose what I thought. You know he was quite hostile, he was someone who had a diagnosis of bipolar disorder and he was quite manic at the time and I just thought it's that kind of manic edge you know when someone isn't happy manic, they're kind of, edgy manic you know it was that kind of situation. I thought well you don't want to talk to me. You're erm finding this obviously a very difficult, I guess I sort of interpreted his reaction to me as sort of like a like a defensive reaction. […] Yeah, yeah. It was definitely sort of like trying to get control, you know, "I'm not going to be asked questions, I'm going to be the one asking the questions" you know, so er, yeah, I just kind of thought, I'm on a bit of a hiding to nothing on this one.* (375-412).

Here we can observe the interdependence of power and resistance. As Foucault wrote "Where there is power, there is resistance" (Foucault, 1978a, p.95). For Foucault in power, as an unstable network of practices rather than a deterministic system of dominating constraints, resistance is always present (Oksala, 2016), "yet or rather consequently, this resistance is never in a position of exteriority to power" (p. 95). The patient can be seen as "trying to get control" by positioning themselves as "the one asking the questions" a position typically occupied by the clinician. This attempt at resistance is constructed by the

clinical psychologist as “hostile” and “passive aggressive”, perpetuating the process of analytic control: pathologising or psychologizing by “interpreting” his resistance as “a defensive reaction” and linking this to his being “unwell”. The resistance is thus interpreted as being “unready” to engage in therapy.

This raises questions about the use of ‘unready’ as a label for those who are resisting being positioned and attempting to hold agency in the therapeutic space. The concept of docile utility is apposite here. “Discipline produces subjected and practiced bodies, 'docile' bodies” (Foucault, 1975, p. 138-9) or in this case ‘docile minds’. RFT is being discursively constructed here as linked to being “amenable” and ”less unwell”. The construction of mental illness is linked to a biddable and controllable subject who will conform to neoliberal principles and aims when they are “well”. Encapsulating the concept of docile utility therefore, the clinician is constructing a ‘ready’ subject who will conform to the norms of therapy, and “engage”, and not one who is resisting the subject position of ‘patient’, ‘client’ or ‘analysand’. She proceeds to label his resistance within this biomedical discourse as a “manic edge” and to take the decision that he is not ‘ready’ for therapy. Again the concept of ‘unreadiness’ is used to support the expert subject position of the clinician.

In summary, this section has presented and analysed the data by attending to constructions of ‘readiness’ as relating to disciplining practices occurring on the ward. These processes of disciplinary and pastoral power, support the expert position of the clinician and maintain their construction as a subject who, within the power-knowledge nexus, holds the capacity to make decisions around readiness for, and therefore access to, therapy. Participants constructed a ‘ready’ therapeutic subject who is normalized and one who does not engage in any form of resistance. In stepping back and examining the effects of sections 3.1 and 3.2 it becomes apparent that the participants are constructing a subject who cannot be ready in the context of an inpatient acute ward. In section 3.3 the question will be posed: how, despite these above constructions, does the clinician construct themselves as an ethical subject?

3.3 The Ethical Clinician: Constructions Of Practice In Relation To 'Readiness' And Macrostructures Of Governmentality

This section will consider how clinicians constructed themselves as an ethical subject in relation to RFT. Having located the responsibility for readiness firmly in the patient, clinicians also allocate responsibility for non-readiness for and non-access to therapy outside themselves, as being in relation to wider systems operating at the 'macro' level such as service structures of inpatient settings, NICE guidance and constructions of therapy itself. In this section governmentality and Foucault's concept of the ethical fourfold, will be drawn upon to examine the context within which these subjectivities and practices are made possible and seen as reasonable.

3.3.1. Services and NICE as a Barrier to 'Readiness' in Acute Inpatient Settings

The following extracts exemplify constructions of services and guidelines in relation to readiness and access to therapy in the acute setting. The extracts exemplify the many ways in which the clinicians constructed 'services', through a variety of different understandings, for example: service structure, length of admission, clinical legislation e.g. NICE guidelines and provision of psychology staff. A particular effort is made to justify therapy not being provided in these settings, reallocating responsibility at the macrostructural level, with 'services' constructed as an obstacle to their ability to provide therapy. These constructions are viewed through the lens of enabling clinicians to construct themselves as an ethical subject despite not providing therapy.

Extract: 16

P1MCP:…*There's not often time to offer people a, a course, so to speak, of therapy whilst they're here. Erm. I mean I think (.) what I feel is that the big gap is that, yeah, we can do things with people while they're here and try our best to help but it's not a continuous thing. In an ideal world we would be able to pick people up here and then carry on seeing them and then offer them a full course of whatever it might be. That's the real gap I think, that we're not able to do that at the moment because it's just, that doesn't really fit with how services are*

organized. […] If you look at NICE guidance or whatever it's very much like, you, if you start something in the acute period you should then be able to continue it through and that's, that's the gap that we've got. It's not that between us we couldn't deliver you know a fairly reasonable range, erm, but yeah. It's the continuing bit that's tricky I think. […] Between my colleague and I we cover erm (.) oh, one, two, three, four, five, six wards and two home treatment teams. So actually yes, for all that we can do various things there's a, a very low chance that you're going to meet us overall. So, I mean, the reality still is that most people who pass through the hospital here or the home treatment team are not having access to any sort of psychological therapy. (374-396; 424-433).

Participant one constructs his provision of therapy as being in line with NICE guidelines. NICE guidance, initiated by the government in 1999, as representing the gold standard of medical practice, can be seen as fundamentally shifting the regulatory relationship between the state and NHS professionals who then have increasing levels of surveillance and control applied to them and their practice (Flynn, 2002). Adoption of these clinical guidelines, with their adherence to 'evidence-based treatments', can be seen in relation to processes of governmentality in which the participant has internalised a conscious awareness of surveillance, implemented via such processes as audit, inspection, observation and evaluation. This enables social control to be implemented as the participant self-regulates in such a way that they are concordant with clinical guidance in order to avoid penalty.
The operation of evidence-based healthcare in this context aligns therapy to biomedical discourses with the clinical psychologist implicitly positioned as a 'scientist practitioner': consumer, evaluator and producer of science (Stoltenberg & Pace, 2007). Scientific knowledge is thus privileged and deployed within the power-knowledge nexus to construct a form of 'best practice' in line with economic and biomedical discourses.

Therapy is constructed here as requiring time, a "full course". Additionally, the requirement for therapy to be a "continuous thing", is stipulated within NICE guidelines (British Psychological Society, 2012). The reference to the "acute period" by participant one is linked to an impossibility of being able to "carry it through" highlighting the role of service structure and length of admissions in

this equation. Therapy is constructed, therefore, as something that is incompatible with macro-structures such as NICE and length of admission. Deploying NICE guidelines, service structure and construction of therapy within biomedical discourses of evidence-based practice, enables the psychologist to talk about the reasons why he is not providing therapy in an apparently unproblematic way. By enabling the functioning of power-knowledge relations at the level of the institution and of governmental guidelines, participant one is able to construct himself as an ethical subject; one, functioning within these processes of governmentality, who would provide therapy if service structures and guidelines allowed him to. Here the subjectivity being formed could be seen in line with Foucault's conceptualisation of the second component of the ethical fourfold – Mode of Subjection (Deontology) as one in which the individual is permitted to perceive their actions as worthy of moral valorization by establishing their relation to the moral code and recognising themselves as bound to act according to it; judging the morality of an action based on rules rather than consequences of an action or, in this case, non-action.

Extract: 17

P10FP:…*Er, I don't think we have enough therapy and psychological support provided in the ward and in a sense that probably is the type of the ward I'm working on, it's an assessment unit. So patients that come there are so disturbed. Most of them are under section. Erm, probably have high risk in terms that they've attempted suicide. They'd be medically erm unwell also because of erm the incident and they might be in a full-blown psychotic or manic episode, that one week or two weeks that they stay with us doesn't give them and doesn't give us enough time to help them slightly improve so they could be reasonably considered for psychological therapy. But for people who are less disturbed and, yes, there has been some previous history before coming to hospital and er their episode is not as significant in the sense of risk*

RR Mmmhmm?

P10 Or in the sense of erm severe psychosis or mania er then in that case we involve the psychologist, probably after a week or two of being in the ward. But for patient who remains acutely disturbed (.) sometimes it's

> *very difficult to, to engage with psychology. And probably the assessment ward is the ward that has (.) less psychology support. Not because the psychologists are not available but it's the profile of the ward. The work we do that doesn't give us enough time to engage everyone in psychological work.* (618-640).

Here we can see the structure of services being constructed as something antithetical to therapeutic work, which is again constructed as something requiring time. The psychiatrist here describes an average stay of two weeks on the assessment ward, highlighting that this "doesn't give us enough time to help them slightly improve so they could be reasonably considered for psychological therapy". Through these constructions the psychiatrist also constitutes herself as an ethical subject who would be referring people for therapy if there were enough time for them to improve slightly so that they could be "reasonably considered" for therapy; or if they were "less disturbed" or not "manic" or "psychotic". Discourses of 'stabilization' and 'distress' (cf. Nykličel and Denollet, 2009; Schneider & Klauer, 2001; Derisley & Reynolds, 2000; Moore, Tambling & Anderson, 2013) and of 'rationality' (Henriques et al, 1998a) preceding RFT have been discussed in section 3.1. However we can see here that the reason for not providing therapy is located both in the service/ward structure and organisation and in the patient who is "manic" or "psychotic" and "high risk" could not, whilst on an assessment ward, be "reasonably" considered for therapy; with "people who are less disturbed" being more likely to be considered. Again the organization of service structures is used to justify inaction. Professional 'norms' of what happens in an 'assessment' unit as opposed to a 'treatment' unit are deployed, thus constructing service structures as instrumental barriers that the participant cannot do anything about. The internalization of these service 'norms', together with risk and diagnosis, again means that the subjectification of the psychiatrist is that of an ethical subject who would ideally like to enable access to therapy but does not due to the rules surrounding best practice. Responsibility is shifted elsewhere and she remains able to construct herself as an ethical practitioner.

In the above extracts processes of subjectification resulted in clinicians' constructions of themselves as an ethical subject, unable to be flexible in order to deliver therapy because they are bound by governmental processes of regulatory power. This process has two outcomes: to state how therapy should be constructed, and to enable the clinician to refuse therapy as, according to NICE it can only be applied in a certain way in certain contexts. Section 3.3.2 will further elucidate the participants' constructions of therapy and their implications for RFT.

3.3.2 Clinicians' Constructions of Therapy in an Acute inpatient Setting.

The participants' constructions of therapy implied it as a positive entity, something that, in an ideal world, patients would want and which should be provided. At the same time, the majority of participants constructed therapy in ways which appear to be antithetical to these ideas: as "an undertaking", "difficult" or "scary", something which "stirs things up" or might "exacerbate the situation" or make the patient more "prone and vulnerable to past emotions" and which may increase risk. Additionally, the majority of participants constructed therapy as something in which the 'ready' subject should be able to "sit in a room for an hour and talk", implying a certain, verbal type of 'ready' subject. These discursive constructions can be seen to function through processes of governmentality, pastoral power and the technology of the confessional (Foucault, 1982), constructing therapy as a fixed entity that the subject needs to transform toward in order to be 'ready' for.

3.3.2.1 The talking cure: Looking back to extract three the clinical psychologist makes the statement "…if you're going to sit with somebody for an hour and they cannot speak to you well then that's probably not going to get you anywhere". In extract eleven the clinician constructs an unready subject who is "sort of up and down out of the chair and in and out of the room". These constructions of therapy, as we have seen, fundamentally rest on the capability and motivation to use language and to abide by social conventions of therapy sessions. Psychology as a 'talking therapy' a term with its roots in Freud's 'talking cure' is inherently dependent on language which is seen by classical metaphysics, as an attribute specific to mankind and what it means to be human. The ability to convey verbal accounts of distress to the clinician constructs a 'ready' subject as a unitary,

individual subject with a core inner self that can be accessed, or not, depending on their ability and motivation to speak to the psychologist; a subject who is the object of psychological theorising and intervention (Venn, 1998); an individual with a 'true' inner self, which can be accessed through personal efforts. The ability to sit in a room for an hour and talk, further links to constructions of Western social conventions of therapy. As Rose (1996) explicates: these 'codes of knowledge' are not accessed purely via introspection but 'by rendering one's introspection in a particular vocabulary of feelings, beliefs, passions, desires, values…according to a particular explanatory code derived from some source of authority' (p 32). Historically and in other contexts, for example this construction of readiness requiring the subject who can "sit in a room and talk for an hour", might have been discursively deployed as the ability to 'lie on a couch' and 'free associate' for an hour.

3.3.2.2 "A difficult process"

Extract: 18

> **P2MCP:…***Mm hm. Well I guess that therapy is a sort of significant (.) undertaking. Um and, erm. Patients kind of can kind of come to therapy with all sorts of expectations and ideas about what it might be about. Um, and, I guess it's ((2)) that sort of, you meet and think about their situation, and you kind of, you offer what you're able to offer. […] Erm, (.) so, sometimes people might come with, sort of, expectations that you're going to somehow going to sort it all out. And that it's not necessarily a process that they're going to be engaged with. It's actually going to be quite difficult for them. You know, it might lead them to talk about difficult things they might not want to talk about, or stir up difficult emotions […]* (363-396).

In relation to RFT, the ready subject is constructed as one who is therefore 'ready' to talk about "difficult things" and that this will be a "process that they're going to be engaged with", not something where the psychologist is "somehow going to sort it all out". These constructions intersect on two levels. Firstly the construction of therapy as "a process" as "difficult" or as something which could "stir up difficult emotions" is built upon ideas of therapy which require the

subject to “go through” certain processes such as revisiting their childhood, the ‘reliving’ of traumatic experiences as a means of ‘processing’ the trauma, working on identifying and changing entrenched ‘dysfunctional’ thinking patterns, or examining ‘unconscious processes’. The ‘ready’ subject is therefore one who needs to be ready for these specific formats or models of therapy; models developed with a middle-class ‘neurotic’ population as opposed to the diverse ‘psychotic’ populations found in acute inpatient wards. Secondly the psychologist’s refuting of the patient’s expectation that they are “somehow going to sort it all out” aligns the psychologist with a position whereby it is constructed as being the patient’s responsibility to work on him or her self. The processes of subjectification here construct a subject with an inner core that is discoverable through therapy. This construction is in line with psychology’s adoption of the positivist, empirical approach; used to establish its scientific status and align itself to the biomedical model. It is, as such, rooted in the historical processes and ideologies of the Enlightenment and structured around such dualisms as Mind-Body, or Society-Individual, representing a Western cultural bias (Cromby, 2006). With distress located within the individual and constructed as illness to be ‘cured’, the subject is thus expected to work on transformation towards a productive and self-regulating neoliberal subject, through technologies of the self. In this ‘”technology of citizenship” (Rose, 1990, p. 227) the subject is expected to lay bare their inner self or soul to a professional thus enabling the idea of the confessional or of pastoral power to function freely by guaranteeing supposedly proper mental hygiene throughout the population (Hansen, McHoul & Rapley, 2003). The ‘ready’ subject is therefore one who approaches therapy, functioning within the technology of the ‘confessional’ (Foucault, 1982), prepared that it will be a “significant undertaking” and is willing to talk to the therapist “about difficult things they might not want to talk about” as a necessity for the therapist as the professional to whom they will “reveal their innermost secrets” (Foucault, 1982).

Extract: 19

> **P10FP:…***And (.) we didn’t feel at the time that working on some psychological therapy about losses she had in the past and some other promiscuous behaviour she had when she had manic episodes would*

help. Probably would exacerbate the situation a bit further. And I didn't feel that that would be the right time to exacerbate the situation of a high-risk patient like that. […] So we thought, well I thought that engaging her ((2)) with psychology or with treatment that will make her more erm (.) prone and erm more vulnerable to past emotions and erm (.) things that she didn't want to discuss and was minimising for years and years and years, was not suitable in this erm high-risk situation. (911-923).

In this extract therapy is, again, constructed in line with Western cultural biases around exposure to difficult memories and emotions: as something which is about "losses in the past", with the potential to "exacerbate the situation further" and psychology as a "treatment with will make her more prone and more vulnerable". The "high-risk patient" would thus be exposed to "to past emotions" and things she had been "minimising for years and years and years". The psychiatrist in extract nineteen also constructs the type of patient in this description as "manic" and "high-risk". This connection of madness and risk functions as a powerful discourse within mental health as a rationale for the need to control and confine. In this case the subject is constructed as unready due to these reasons and therefore does not have access to therapy. Within these constructions of therapy as exposure to difficult emotions, the clinicians' again enter into self-disciplining technologies of power: their constructions of themselves as ethical subjects continues to be present as practitioners who are not exposing the patient to these experiences as they are "vulnerable" and it is not "the right time to exacerbate the situation".

This section has attended to processes of governmentality and pastoral power enabling subjectification of the clinicians as ethical practitioners. Constructions of 'services', 'NICE' and 'therapy' intersect to act as barriers to the patient being able to access therapy as they cannot be considered 'ready' within these parameters. The discussion chapter will provide a summary and evaluation of this research and offer recommendations for clinical research and practice.

CHAPTER FOUR: DISCUSSION

This chapter will summarise the main outcomes from the analysis. The research will then be evaluated with attention to coherence, rigour, sensitivity to context, transparency and reflexivity (Yardley, 2008). Finally the implications of the research for future research and clinical practice will be considered.

4.1. Research Questions and Analysis Summary

The research focused on three questions:

- How do clinicians construct their understanding of the concept of readiness for therapy?
- How is the discourse around readiness for therapy functioning in inpatient services?
- How does the construct of 'ready' or 'not ready' position someone in relation to inequalities in access to therapy and what are the potential consequences?

4.1.1 How Do Clinicians Construct Their Understanding of the Concept of Readiness for Therapy?

Broadly RFT was constructed in relation to criteria required from a therapeutic subject who was constructed, through processes of normalisation and subjectification, as needing to occupy a subject position of 'ideal therapeutic subject'. Processes of subjectification of the ideal 'ready' subject occurred through two processes: the positioning of the subject as rational and resourced and the discourse of stabilisation - both constructed as prerequisites for RFT.

4.1.1.1 Rationality, resources and 'pollution': The 'ready' subject was constructed by the clinicians as possessing 'insight', which was in itself positioned as being concurrently a prerequisite for therapy but also a potential outcome of therapy. I have argued that 'insight' functions as a technology of power, directly implicating psychology as part of the psy-complex (Rose, 1990) as having the potential to 'achieve socially desirable objectives through the

disciplining of human differences' (Louw, 2005). I also argued that a 'responsibilization' (Rose, 1999) discourse functioned to construct the ideal 'ready' subject in line with David's (1990) criteria describing 'insight': willingness to label experiences as pathological, acceptance of mental illness and agreement with treatment (David, 1990). The ideal 'ready' subject constructed by the participants can be seen to be 'rational' and responsibilised through technologies of the self, adhering to the truths and norms of psychiatry and psychology in order to be considered ready for therapy. Further, madness, or 'thought disorder' is constructed as 'polluting' to the therapeutic interaction, a powerful discursive positioning which constructs the 'unready' subject as someone who is to be confined, not treated (or at least not by therapy), and as a threat to rationality. This can be seen in relation to Foucault's descriptions of the shift in understanding of and treatment of madness in the mid-17th century as falling outside the spectrum of what was considered human and linked to the need for confinement. Processes of subjectification could be seen to position the clinicians as gatekeepers of therapy as a resource. Alignment with the version of reality provided by professionals, positioned as 'common sense' (Miller and McClelland, 2010), was required, implying the exclusion of those who do not adhere to norms of rationality. Within an inpatient setting the implications for access to therapy are startling: the construction of the subject as 'too disturbed' may refer to any number, if not the majority, of patients admitted to the ward. This subject-positioning can be seen in relation to constructions of 'distress' in relation to RFT in the literature (Nykličel and Denollet, 2009; Schneider & Klauer, 2001; Derisley & Reynolds, 2000; Moore, Tambling & Anderson, 2013).These discourses of exclusion can be seen as reflected in the absence of literature in this area, as noted in the literature review; and thus the exclusion of the patient in these settings, both materially and conceptually, from therapy.

As outlined in the literature review, the ideal therapeutic subject was also constructed through a discourse of 'personal resources' including: intelligence, verbal agility and emotional strength (Heilbrun & Sullivan, 1982; Truant, 1999; Ogrodniczuk et al, 2009). I have argued here that the clinicians constructed a therapeutic subject who is, in many ways, like them: a white, middle-class, educated subject. Therapy, seen as a transforming technology of power would

make them ‘well’ and therefore ‘productive’, in line with neoliberal values. However, they do not have access to these transforming technologies as they do not fulfil the criteria of rationality and personal resources outlined by the clinicians. They do not have the ‘cultural capital’ (Bourdieu, 1986) required to gain access to therapy.

4.1.1.2 ‘The Goldilocks Paradox’: The second major argument put forward in the analysis was that patients were also prevented from being constructed as ‘ready’ due to the ‘goldilocks paradox’: a construction of RFT in which the subject who is a patient on an inpatient ward cannot be considered ‘ready’ due to timing, location and requirements for mutually exclusive internal states, echoing the literature which demonstrates contradictory findings on the role of ‘distress’ in assessing for RFT (Nykličel and Denollet, 2009; Schneider & Klauer, 2001; Derisley & Reynolds, 2000; Moore, Tambling & Anderson, 2013). Disciplining practices can be understood in this context as a means of control of the patient who, through processes of subjectification, is expected to form themselves as an entity who will occupy an idealised position, creating such narrow conditions of possibility (Foucault, 1966) that very few patients will be assessed as being ready for therapy, thus enabling the psychologists to manage their resources.

In summary, the clinicians can be seen to be managing accountability, creating an ideal subject who, in the context of the ward, is never going to meet the criteria for RFT. If they are then, due to being deemed ‘not ready’, denied access to those transforming technologies of the self, i.e. therapy, they are therefore left to other technologies present on the ward: those disciplining technologies: observation, surveillance and medication; described in the second discursive site, below.

4.1.2 How is the Discourse Around Readiness for Therapy Functioning in Inpatient Services?

Constructions of RFT at the level of the ward environment saw disciplining practices of surveillance underpinning assessment of RFT. I have argued here that 'unreadiness' can be seen as a tool supporting the expert position of the clinicians. Constructions of 'presentation' on the ward could be seen as enabling deployment of power-knowledge relations at the level of surveillance; whilst negotiations of subjectivity and resistance within the ward environment were positioned as 'unreadiness' and pathologised by clinicians. Facets of disciplinary technology manifest through coding of behaviour and through processes of normalisation which constructed an 'unready' subject as one who does not behave according to the rules and norms of the ward and does not construct themselves as a regulated, neoliberal subject.

A discourse of 'ability/willingness to discuss personal matters openly' could be seen to be deployed by the clinicians. The functioning of pastoral power via the technology of the confessional (Foucault, 1982) thus recruits the psy-complex as complicit in processes of governmentality, ensuring "mental hygiene" throughout the population (Rose, 1992). I have argued here that the patient is expected to demonstrate adherence to these conventions through clinical practices on the ward: conventions of therapeutic sessions in the case of psychology and conventions of the ward round in the case of psychiatry.

Negotiations of subjectivity and resistance within the ward environment were also discursively deployed by the clinicians as pathologising potential attempts at resistance on the part of the patient. The implications for subjectivity can be seen through the lens of docile utility: constant surveillance inducing a psychological state of 'conscious and permanent visibility' (Foucault, 1975), internalised to construct a self-aware, self-regulating neoliberal subject. A docile body - or, in this case, mind - conforms to the norms of therapy, does not resist the subject position of 'patient', 'client' or 'analysand' and does not attempt to resist individualising discourses of illness and responsibilization (Rose, 1999; Patel, 2003). The power-knowledge relations implicated here thus depend on expert knowledge deployed to construct a reality in which the patient is in a

subjugated position and must adhere to the norms of the ward or be labelled ‘unready’ and denied access to therapy.

4.1.3 How Does The Construct Of ‘Ready’ Or ‘Not Ready’ Position Someone In Relation To Inequalities In Access To Therapy And What Are The Potential Consequences

I have argued that, in inpatient settings, patients were also positioned as unable to access therapy due to macrostructural issues. Through technologies of the self (Foucault, 1988) these macrostructures: services, guidelines and therapy were discursively deployed to facilitate the clinicians’ subjectification of themselves as ethical practitioners, despite not providing therapy. The subject position of ‘ethical practitioner’ was understood as being constructed in relation to the second component of the ethical fourfold (Foucault, 1984a, 1984b): ‘mode of subjection’. Judgement of ethical behaviour is, herein, based on adherence to rules rather than consequences of the behaviour, in this case: not providing therapy. Three discursive constructions: NICE guidelines, service structure and therapy intersect, functioning as regulatory power structures within processes of governmentality. These macrostructures are constructed as antithetical to one another: Service structures indicate that acute admissions are short - Patients will usually spend fewer than 90 days on an acute inpatient ward. Some areas sub-dividing acute wards into assessment/triage and short-term admission with average stays of seven days and standard treatment wards with average stays ranging from 20 to 90 days (NHS Confederation, 2012; Williams et al, 2014), therapy is constructed as a long process, and both constructions on the part of the participants and guidelines which state therapy should be continuous (NICE 2014). They are thus constructed as preventing the psychologist from being able to deliver therapy in acute inpatient services.

Therapy was constructed by the clinicians via two discursive processes: as a difficult process requiring exposure to painful memories and emotions (cf, Hoffman, 1969); and as inherently dependent on language and the ability to convey verbal accounts of distress. The construction of therapy as inherently verbal could be seen to presuppose a ‘ready’ subject as a unitary, individual subject with a core inner self that can be accessed, or not, depending on their

ability and motivation to speak to the psychologist; a subject who is the object of psychological theorising and intervention (Venn, 1998); an individual with a 'true' inner self, which can be accessed through personal efforts. The ability to sit in a room for an hour and talk further links to constructions of Western social conventions of therapy, demonstrating the historically and culturally constructed nature of therapy.

Through the technology of the confessional (Foucault, 1982), the 'ready' subject is constructed as willing to "reveal their innermost secrets" (Foucault, 1982). However, this can be seen to interact with discourses of risk whereby therapy as a 'difficult process' was positioned as potentially 'destabilizing' the patient. Self-disciplining technologies of power thus facilitate the clinicians' constructions of themselves as ethical subjects, practitioners who are not exposing the patient to these difficult experiences of therapy as they are "vulnerable" and "risky".

The differences in power relationships in this environment mean that the clinician has more power and control over the client's life than at any other point in mental health services (Laugharne, Priebe, McCabe, Garland and Clifford, 2012) whilst the patient is unable to seek support elsewhere. I argue that the consequences of these three discursive sites are to construct barriers to therapy through the processes of subjectification, disciplining practices and ethical technologies of the self with the result that patients in inpatient settings are unavoidably constructed as not ready for therapy and are consequently unable to access therapy. With reduced funding and an absent research focus on therapy in inpatient services the impasse arising from these constructions of RFT, and ways out of the impasse, will be discussed in section 4.4.

4.2. Evaluative Criteria

Willig (2001) maintains that evaluation should be compatible with the epistemological approach of the research, further suggesting that Foucauldian discourse analysis is most usefully evaluated by "assessing the quality of the accounts they produce. Do they tell a good story? Do they tell a story which is clear, internally coherent and sufficiently differentiated? Does it generate new

insights for readers?" (p148). Attention has been given, both in the analysis chapter and in the summary of findings, to demonstrating the links made between the data and my interpretations in order to describe a clear and coherent story. In addition to this I will employ evaluative criteria drawn from Yardley's (2008) framework, comprising: coherence, transparency and rigour and impact (Yardley, 2008). Issues of reflexivity will be addressed in section 4.3.

4.2.1 Coherence

Coherence in qualitative research is considered by whether it is able to provide a clear and persuasive argument and whether this forms a congruent whole with the methods employed and their theoretical background. The interrelation of the theoretical approach, research question, methodology and analysis (Yardley, 2008) is therefore central: the grounding of the research questions in the epistemological stance and methodology of this study has been key in demonstrating a coherent approach to the research. Compatibility of language and method has been demonstrated in line with Yardley (2008) with attention to 'discursive constructions', for example, as opposed to 'findings'. The process of analysis was multilayered and iterative generating many possible avenues of exploration. Patterns were attended to at both micro and macro levels, attention to exceptions or 'counter-discourses' in the data further potentiating sensitivity to these patterns. The research questions have been revisited and summarised in relation to the literature and the overall argument of the thesis. Coherence of analysis and assimilation of the literature has been demonstrated through attention to the three discursive sites - presenting the multifarious constructions of RFT in order to provide clarity on the connections between the extracts and the discursive constructions.

4.2.2 Transparency and Rigour

Several processes enabled rigour in the conduction of this research. Use of memories as data (Haug, 1987), enabled an in-depth engagement with the topic, both by participants and researcher, pre and during the interview process. Immersing myself in the literature of Foucault and associated thinkers, as well as seeking out research supervisors who had extensive knowledge of FDA, enabled me to ground the research in the conceptual and theoretical roots of a

Foucauldian approach to discourse analysis. Finally, attention to sensitivity to context[18] and to epistemological and personal reflexivity [19] enabled an in-depth analytic process.

Yardley (2008) suggests that transparency can be demonstrated by providing adequate detail of the methodology employed, including a 'paper trail', which documents the process of the research as having been carried out to a professional standard.[20]

4.2.3 Limitations

Recruitment of participants from a small group may have limited the diversity of the data. Starting processes of recruitment earlier may have enabled the researcher to recruit a more diverse professional population. Memory work (Haug, 1987; Crawford, Kippaz and Onyx, 1992) was only carried out partially. Had the interview process been started earlier it may have been possible to carry out the memory work more fully[21] which would have produced additional in-depth data and may have resulted in more naturalistic conversations which would also have reduced my influence over the data as a researcher.

4.3 Reflexivity

4.3.1 Epistemological Reflexivity

The epistemological position adopted in this research was aligned with both a social constructionist stance and with critical realism. Willig (1999) suggests that constructions available are dependent on historically and culturally available ways of understanding phenomena, and that understanding is therefore contextual (Willig, 1999). In reflecting on the epistemological position taken in this study it is necessary to consider the argument that adopting an ontologically realist stance which is underpinned by epistemological relativism could lead to inconsistent applications in relation to which objects and subject are reified and which are not (Speer, 2007). The importance of accounting for the material effects of discursive constructions was acknowledged by the use of a Foucauldian discourse analysis and could be seen to address these criticisms:

[18] See section 2.6.2.5 for further information on sensitivity to context.
[19] Addressed in section 4.4
[20] See Appendix J for an example of the analysis forming part of the paper trail
[21] See Appendix K for a detailed description of the memory work method

critical realism, according to Parker (1992) acknowledges the material nature of the human world whilst asserting that understandings of the world and practices are constructed through language (Parker, 1992). An examination of the impact of professional constructions of RFT on both the patient and clinician was an integral part of the research questions of this thesis, and the adoption of an integrated critical realist, social constructionist, non-relativist stance enabled this process. It is important to acknowledge that my analysis is just one interpretation of the data and that this thesis is, in itself a discursive construction. It is important to highlight the potential impact of the interview process in and of itself on the data. Potentially my asking these questions of the participants could have put them on the spot so they were therefore taking a discursive position whereby they felt the need to justify or construct rationales for not providing therapy. The importance of a reflexive stance, both epistemologically and personally, is therefore central throughout the research process in acknowledging the impact of what I bring to the construction of this knowledge; for example, my positioning as 'insider' or 'outsider' in relation to the participants.

4.3.2. Personal Reflexivity

As already discussed in chapter two, a reflexive journal has been kept throughout the process of research. My clinical and research experience has informed how I have understood ideas around RFT. Personal reflexivity is integral to consideration of 'good' qualitative research in providing an account of how the research and the object of inquiry will have been shaped by the researcher (Willig, 2013). Throughout the research process I have reflected upon differing aspects: clinical, research and previous training, which may have influenced my construction of the data.

It was noticeable how the clinical area of work I was undertaking whilst conducting my analysis impacted on my reading of the data. For example, working in a service that provides 'treatment interventions' to children who have experienced trauma, I found it challenging to extricate myself from clinical discourses of evidence base around 'exposure' as an integral and necessary aspect of treatment. Through discussion with my research supervisors and through use of my reflexive journal I was able to reposition my interpretation of

this material in alignment with the methodological approach taken in the study and to acknowledge the cultural and social construction of these assumptions.

My previous training as a music therapist has permeated the research process - from the initial idea to explore the construct of RFT to my reading of the data and resultant analytic foci. My belief that therapy can and should be adjusted to meet the needs of the person using it, whether verbal or non-verbal, can therefore be seen to have underpinned this research.

Finally, whilst I, unavoidably, had an impact in shaping and constructing the research, the research in itself and the process of interviewing professionals and analysing these interviews, has also shaped my understandings and view of therapy. From an initial position in which I was not particularly critical of therapy as a construct, seeing it as a positive and supportive process, I have been guided to more critical understandings of therapy through the analytic process and thought incorporation of critical concepts present in the literature such as the psy-complex (Rose, 1990) and the Foucauldian ideas underpinning the analysis. I feel that I have come away from this research with different understandings of therapy in and of itself, and can see its potential to be both a positive force and to be wielded as a technology of power (Foucault, 1975). I remain unchanged in my belief, however, that therapy can and should be adjusted to meet the needs and desires of those who wish to participate in it.

4.4 Impact and Recommendations

4.4.1 Implications for Future Research

As highlighted in chapters one and three, although psychologists and other therapists are working in these services, there is an absence of literature on RFT in acute inpatient settings. The dearth of research in this area serves to exclude madness from theoretical considerations of RFT in inpatient settings and perpetuates its exclusion from therapy itself. An absence of literature on RFT in inpatient settings could be one reason, alongside practical issues of funding and availability of therapies, why clinical and institutional guidelines (NICE 2009) are not being adhered to but instead have the potential to be employed to enable clinicians to manage their resources and accountability,

resulting in the potential for therapy not being accessed by the majority of those admitted to inpatient services. Within a realist epistemological framework there are understandable challenges in carrying out research on a heterogeneous population such as those found in acute inpatient settings. At the most basic level however, RFT in this context could be explored in relation to the therapeutic needs of those on the wards and not solely, as is represented in the literature, in relation to concurrent substance misuse issues (cf. Heesch, Velazquez & von Sternberg, 2005; Pantalon & Swanson, 2003).

This is not to suggest, however, that research within a realist paradigm would be the recommended position for future research. Indeed, further qualitative research into the area of RFT or other of the related constructs such as psychological-mindedness or engagement would be crucial in counterbalancing the dominance of realist knowledge-claims currently privileged in this field. Further, future research could helpfully address the current positioning of alternative forms of therapeutic provision which position themselves as outside the realist associations of evidence base, for example, narrative and systemic approaches. Current expectations of evidence-based practice and outcome measures, aligned to a biomedical, realist stance towards knowledge generation, positions post-structuralist approaches at a disadvantage as they do not subscribe to the same epistemological or evaluative framework (Laugharne, 1999). Additionally, therapeutic approaches with a relatively small and emerging body of research, for example the arts therapies, also occupy a non-privileged position in service provision. Research on therapeutic approaches which are able to adapt to the needs and abilities of the patients in inpatient settings would therefore be a valuable addition.

Finally, and possibly most importantly, exploratory, participatory research to include patients admitted to acute inpatient wards would be a crucial element in exploring understandings of RFT from the patient's perspective. Fundamentally, future research may need to step outside the Eurocentric constructions of therapy, and therein RFT, to explore non-linguistic ways of understanding distress and therapy.

4.4.2 Implications for Clinical Practice

The construction of RFT as requiring an ideal subject who, even if they existed in an inpatient setting, would nonetheless be prevented from accessing therapy due to service structures and the constrictions of therapy, clearly has implications for clinical practice: in provision of and access to therapy . The question arises: How *could* someone be understood as ready for therapy when the institutional systems are in place to stop them, when the pathologising of the person is in place to stop them? And crucially: what might therapy for an 'unready' or 'mad' person look like?

The dominance of CBT in alignment with the biomedical framework has the effect of placing constrictions on the majority of clinicians working in clinical psychology. The origin of CBT can be seen within a Eurocentric and reductionist stance towards scientific knowledge, which considers that there are discoverable, objective truths located within the person (Boyle, 2011).
In the context of RFT this positions the person as problematic and 'unready' rather than the therapeutic approach as unsuitable for the individual at that point in time.

4.4.2.1 Alternative Therapeutic Approaches: Open Dialogue and the Arts Therapies: Cornish and Gillespie (2009) outline the scope for adopting a 'pragmatic' approach reflecting pluralist, non-relativist, critical practice which is action-focused in its use of knowledge and is evaluated according to whether the interests of those using the approach are served. Additionally, the systemic position *both/and* (Burnham, 1992) could be usefully deployed here to explore avenues of practice within clinical psychology which would integrate the most beneficial aspects of diverse approaches. As discussed, the impetus to impose a certain version of reality on the patient can have negative impacts upon self-identity (Beck-Sander, 1998). This study would recommend alternative approaches to therapy that do not pathologise the individual but instead listen to their meaning-making, even if this meaning-making is 'unreasoned'. Open dialogue (Seikkula et al,1995) could be employed, enabling meaning to be co-constructed between patient, family and professional and re-constructing 'psychosis' as an attempt to communicate experiences where words are not yet possible (Stockman, 2015). In many respects open dialogue shares numerous

theoretical underpinnings with the arts therapies. Whilst each of the arts therapies (ATs) employs different techniques, the emphasis on non-verbal communication and creative processes as dialogue are central to all modalities. The understanding of processes of verbal communication as arising out of the early, pre-verbal caregiving relationship is also common to both open dialogue and music therapy. Based on the theoretical research of Vygotsky (1987) and Trevarthen (2017) The dialogue, begun immediately after birth, of facial expressions, verbalizations, movements and shared attention to the world is seen as forming a development of communication in which caregiver and baby begin to influence each other's emotional states and behaviours. The development of language, in parallel with emotional development, is understood as a process in which the caregiver's voice as gradually internalised by the child, eventually forming inner speech and ability to self-regulate. These conceptualisations of language development and emotional regulation serve several functions, which could be seen to be beneficial in inpatient settings and, more specifically in relation to RFT:
Distress is understood as something that may not be able to be understood on a cognitive level or translated into words at that moment. Verbal communication is not a prerequisite for engagement and inclusion in the 'treatment'. Finally the 'ready' subject is understood as decentered and in relation to their context.

Additionally, the use of different creative modalities of the AT's, which admittedly contain their own conventions, would nonetheless support a shift away from a therapy which requires the 'ready' therapeutic subject to conform to Eurocentric conventions of sessions originating in the work of Freud, toward a more flexible approach which moves to meet the patient in a therapeutic space they can mould and direct according to their needs.

4.4.2.2 The Power Threat Meaning Framework: A pragmatic approach may, however, potentially result in inconsistent strategies, which would not coherently resist bio-medical constructions of distress. The PTM framework could potentially be beneficially employed in inpatient services by providing an alternative way for patients and clinicians to talk about 'emotional distress' or 'troubled behaviour'; to understand and emphasise the link between these and social factors such as discrimination, inequality and poverty as well as adverse

experiences such as abuse and violence. The potential, through this alternative understanding could enable both clinicians and patients to reallocate ideas around blame, weakness, deficiency or mental illness through different narratives about people's lives and difficulties (Johnstone & Boyle, 2018).

The suggested questions which summarise the main conceptual aspects of the PTM framework could be helpfully employed in many arenas of inpatient services whether that be an initial meeting between clinical psychologist and patient or the discussions held in ward round. The questions include:

- What has happened to you? (How is **Power** operating in your life?)
- How did it affect you? (What kind of **Threats** does this pose?
- What sense did you make of it? (What is the **Meaning** of these situations and experiences to you?)
- What did you have to do to survive? (What kinds of **Threat Response** are you using?).
  (Johnson & Boyle, 2018)

In relation to decisions around RFT this framework and line of questioning could aid in shifting the location of the problem and responsibility for 'readiness' to an external position, rather than situating them in the pathologised inpatient who cannot realistically meet these expectations and judgments.

Implications relevant to psychiatric practice in relation to RFT could also make use of the PTM framework. Psychiatrists, in the position of referrer, may make implicit judgments around readiness based on their observations of patients and their 'presentation' at ward round which is a site of considerable disciplinary power. It has been described how patients can be positioned in the context of ward round with Duggins (2010) suggesting that patients attending ward rounds are characterised as "good patients" who are accepting of care plans or "difficult patients" who wish to discuss their distress and may question treatment rationale. Use of the above questions from the PTM framework could aid the psychiatrist and MDT to enable the patient in discussing their experiences in

different ways without the requirement to deploy ‘cultural capital’ (Bourdieu, 1986) in aligning to a diagnostic worldview.

4.4.2.3 Attention to Language: Linked to the differing constructions of therapeutic and psychiatric practice, attendance to language used both in assessments and in ward rounds would be significant in effecting change in the positioning of the patient. The importance of discourse in creating or maintaining ‘regimes of truth’ (Foucault, 1975) which are unhelpful is fundamental. The potential for creation of alternative, more helpful ‘truths’ thus rests on a shift in language away from individualizing, pathologising discourses. In line with the ‘pragmatism’ described above, a solution-focused approach, attending to the constructive power of language in our social realities (de Shazer et al, 2007) may be helpful in the search for alternative discourses. Additionally, training in differing modalities of communication may support alternative ways to conduct therapeutic sessions for clinical psychologists working within these settings, facilitating the clinician to move past an expectation for the patient to ‘sit in a room and talk for an hour’.

4.4.3 Recommendations for Clinical Practice

It should be acknowledged that the requirement to simultaneously comply with clinical guidance, whilst working in inpatients services and carrying out therapy as understood by the discourses and constructs present in this analysis, can be seen to result in a place of stuckness and possible stalemate for those clinicians working in these settings. A tentative conclusion to this dilemma could ask the question: is clinical psychology currently fit for purpose in these settings? And what can be done to in the professions of clinical psychology and of psychiatry to shift these practices?

On a broad level, rather than requiring patients to fit into narrow conceptual and clinical boxes, clinical psychology and psychiatry could shift to a more flexible, culturally sensitive way of providing therapy allowing for different ways of working that fit the needs of the groups and individuals they are working with. This could include:

- Use of different therapeutic models should be formulation-led as opposed to rigidly applied, challenging realist notions of 'validity' in order to meet the needs of the patients in these settings and challenging diagnostic or biomedical constructions of distress.
- The use of different models such as open dialogue (discussed above), trauma-focused work which acknowledges the potential root of difficulties associated with a diagnosis of psychosis (or complex trauma in the case of diagnosis of personality disorder) as located in a person's context and life experiences, and narrative approaches which encourage meaning-making within the individual's context.
- In asking questions about an individual's readiness for therapy in inpatient settings, past experience of these settings should be thought about in collaboration by the clinical psychologist, the psychiatrist and the patient in a transparent way. For example, meaning making, as mentioned above in relation to narrative approaches, has the potential to explore the context of a subject who is not able to 'sit in a room and talk' with the clinician. Silence within these settings could be supportively explored in the context of what it means to the patient to be silent. Potentially it is safer for them not to engage as previous experiences of talking or 'engaging' may have resulted in negative consequences such as being pathologised or placed under a section of the Mental Health Act. Understandings of the possibility that 'engagement' could now feel unsafe for an individual in these contexts could help clinicians to support individuals in a meaningful way.
- Psychologists should be politically active, aiming to influence change at a meta-level. This could encompass changes to both NICE guidelines and to the teaching of psychology at both undergraduate and doctoral levels:

<u>NICE Guidance</u>

NICE guidelines should be amended to reflect the length of stay in inpatient services and to enable clinicians to continue providing therapy post-discharge. Although it should be acknowledged that the construction of therapy as needing to be 'continuous' is simply one construction, it has also been found that patients can find it difficult having to tell their story repeatedly to multiple professionals (Biringer, Hartveit Sundfør Ruud & Borg, 2017). Additionally, the

NICE guidelines for schizophrenia and psychosis currently recommend CBT for psychosis (CBTp) based upon research evidence from 5 randomised controlled trials which omitted from the analysis those with the most severe symptoms (NICE, 2014 pp 119). In the context of this study and discourses around difficulties in implementing/absence of CBTp in these settings, it would be recommended that NICE guidelines are also revised to support therapeutic approaches which the populations of inpatient settings, are able to access, such as open dialogue or non-verbal forms of therapies, e.g. the arts therapies as discussed above, giving emphasis to culturally located understandings of distress.

Trainings

Narrow understandings and constructions of RFT or of the 'ready' subject could be seen to stem from

- Constructions taught at undergraduate level, for example "abnormal psychology", which could potentially encourage a limited and limiting conceptualisation of what it means to be human.
- A split between clinical psychologists and the groups they work with. i.e. those of lower socioeconomic status and/or differing ethnic backgrounds, resultant in socio-culturally-situated expectations around a 'ready' subject.

As therapy and the ready subject are constructed in this study within a narrow range of subjectivities, primarily those which mirror the socioeconomic, educational and ethnic backgrounds of the participants, we may need to examine how the training courses support and broaden the experiences of trainees who may have little experience of other cultures, giving clinical psychologists more tools and better understandings to address the needs of the populations they work with and to work sensitively with these discrepancies.

This thesis has looked at how readiness for therapy is discursively constructed by clinicians working in inpatient acute settings. Through examining their constructions of RFT we can see how a seemingly 'common sense' concept has the capacity to impact the subjectivities of both patients and clinicians, and their access to therapy, highlighting the importance of evaluating the concepts used in clinical psychology in order to expand our practice and give equal

weight to the voice of the patient. In the words of Bakhtin: **“**A plurality of independent and unmerged voices and consciousnesses, a genuine polyphony of fully valid voices” (Bakhtin, 1993).

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APPENDICES

APPENDIX A: Overview Of Power Threat Meaning Framework

The Power Threat Meaning Framework: Summary Core principles of the PTM Framework

The Power Threat Meaning Framework is a new perspective on why people sometimes experience a whole range of forms of distress, confusion, fear, despair, and troubled or troubling behaviour. It is an alternative to the more traditional models based on psychiatric diagnosis. It applies not just to people who have been in contact with the mental health or criminal justice systems, but to all of us.

The Framework summarises and integrates a great deal of evidence about the role of various kinds of power in people's lives; the kinds of threat that misuses of power pose to us; and the ways we have learned as human beings to respond to threat. In traditional mental health practice, these threat responses are sometimes called 'symptoms'. The Framework also looks at how we make sense of these difficult experiences, and how messages from wider society can increase our feelings of shame, self-blame, isolation, fear and guilt.

The main aspects of the Framework are summarised in these questions, which can apply to individuals, families or social groups:

- 'What has happened to you?' (How is **Power** operating in your life?)
- 'How did it affect you?' (What kind of **Threats** does this pose?)
- 'What sense did you make of it?' (What is the **Meaning** of these situations and experiences to you?)
- 'What did you have to do to survive?' (What kinds of **Threat Response** are you using?)

In addition, the two questions below help us to think about what skills and resources people might have, and how we might pull all these ideas and responses together into a personal narrative or story:

- 'What are your strengths?' (What access to **Power resources** do you have?)
- 'What is your story?' (How does all this fit together?)

Possible uses of the PTM Framework

The Power Threat Meaning Framework can be used as a way of helping people to create more hopeful narratives or stories about their lives and the difficulties they may have faced or are still facing, instead of seeing themselves as blameworthy, weak, deficient or 'mentally ill'. It highlights the links between wider social factors such as poverty, discrimination and inequality, along with traumas such as abuse and violence, and the resulting emotional distress or troubled behaviour. It also shows why those of us who do not have an obvious history of trauma or adversity can still struggle to find a sense of self- worth, meaning and identity.

The Framework describes the many different strategies people use, from automatic bodily reactions to deliberately-chosen ways of coping with overwhelming emotions, in order to survive and protect themselves and meet their core needs. It suggests a wide range of ways that may help people to move forward. For some people this may be therapy or other standard interventions including, if they help someone to cope, psychiatric drugs. For others, the main needs will be for practical help and resources, perhaps along with peer support, art, music, exercise, nutrition, community activism and so on. Underpinning all this, the Framework offers a new perspective on distress which takes us beyond the individual and shows that we are all part of a wider struggle for a fairer society.

One of the most important aspects of the Framework is the attempt to outline common or typical patterns in the ways people respond to the negative impacts of power - in other words, *patterns of meaning-based responses to threat*. This part of the Framework, like all of it, is still in a process of development. However, the evidence summarised in the Framework does suggest that there are common ways in which people in a particular culture are likely to respond to certain kinds of threat such as being excluded, rejected, trapped, coerced or shamed. It may be useful to draw on these patterns to help develop people's personal stories. These general patterns can help to give people a message of acceptance and validation. The patterns can also assist us in designing services that meet people's real needs, as well as suggesting ways of accessing support, benefits and so on that are not dependent on having a diagnosis.

In addition, the Framework offers a way of thinking about culturally-specific understandings of distress without seeing them through a Western diagnostic model. It encourages respect for the many creative and non-medical ways of supporting people around the world, and the varied forms of narrative and healing practices that are used across cultures.

Taking the PTM Framework further

It is important to note that Power Threat Meaning is an over-arching framework which is not intended to replace all the ways we currently think about and work with distress. Instead, the aim is to support and strengthen the many examples of good practice which already exist, while also suggesting new ways forward. The Framework has wider implications than therapeutic or clinical work. The main document (link below) suggests how it can offer constructive alternatives in the areas of service design and commissioning, professional training, research, service user involvement and public information. There are also important implications for social policy and the wider role of equality and social justice. It is a work in progress, offered as a resource for any individuals, groups or organisations interested in developing it further.

APPENDIX B: Table 1. Links between therapeutic orientations and understanding of Readiness for Therapy (RFT)

This table will clarify how the constructions of RFT map onto therapeutic approaches and address the key issues. Please note that this table is, in itself, an illustrative construction; it is only one representation of constructs which are rarely straightforward, are multifactorial and conceptually overlapping. Furthermore, clinical psychologists do not tend to understand their clients solely from one position.

Therapeutic Approach	**Constructions of Therapy**	**Main focus & Assumptions of the human subject**	**Understandings of what constitutes RFT**	**Constructions of RFT**
Psychoanalytic	- Subject gains self-knowledge through expertise of therapist	- Intra-relational, intra-psychic - A 'non-rational' decentred subject: driven by unconscious processes such as defence mechanisms and splitting	- Introspection, projection and isolation - Psychological-mindedness, - Acceptance of patterns as maladaptive - Psychic pain - Intra-psychic flexibility	- Readiness - Suitability - Psychological-mindedness
Cognitive Behavioural	- Collaborative - Negative behaviours and faulty cognitions identified and corrected by therapist	- Intra-relational - A rational unitary subject: able to recognise their thoughts, feelings and behaviours as 'irrational' and amenable to modification	- Accessibility of automatic thoughts and the awareness and differentiation of emotions, thoughts and behaviours - Compliance with treatment - Completion of treatment	- Readiness for change - Motivation - Insight - Engagement
Narrative Systemic	- Involving family and network. - A conversation as a journey with no single correct direction	- Inter-relational - Focus on the role of language in the construction and experience of the self - Individual viewed as part of their family system and cannot be fully understood in isolation	- Ability to re-author or co-create a narrative account of the development of the problem - Context and relationship factors viewed as important for the 'fit' of therapy to patient	- Excavation of the dominant story: client as "fused" with their story - Curiosity

Appendix C: Table 2: Summary of dimensions covered by insight scales

Dimension of insight	PANSS	ITAQ	SAI	SUMD	BCIS
1. Acceptance of illness label	X	X	X	X	
2. Awareness of having a mental disorder			X	X	
3. Perceived need for treatment		X	X		
4. Awareness of treatment benefiT				X	
5. Attribution of benefits to treatment		X			
6. Awareness of signs and symptoms			X	X	X
7. Attribution of signs and symptoms to having a mental disorder				X	X
8. Awareness of social consequences of illness				X	X
9. Lack of judgement		X			

(Tranulis, Corin & Kirmayer, 2008 p. 231)

PANSS = Positive and Negative Syndrome Scale (Kay et al., 1987)
ITAQ = Insight and Treatment Attitude Questionnaire (McEvoy et al., 1989) SAI = Schedule for Assessing the three components of Insight (David et al., 1992)
SUMD = Scale to assess Unawareness of Mental Disorder (Amador et al., 1993)

APPENDIX D: University of East London Ethical Approval

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Laura McGrath **REVIEWER:** Neil Rees

STUDENT: Rowan Reiss

Title of proposed study: Constructions of Readiness for Therapy on Adult Acute Wards

Course: Professional Doctorate in Clinical Psychology

DECISION *(Delete as necessary)***:**

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

I'm not convinced that you have attended enough to the issue of possible deception in section 3.2. The rationale for not fully informing potential participants is clear but this may cause some consternation, particularly as you will provide a summary of the research to participants and if we keep your 3rd research question in mind re: inequalities in access to therapy. Participants may feel unfairly deceived.

You say that you will seek consent again at the end of interview but you don't say you will give participants any further information about your research questions or approach to analysis before seeking this second consent so it's unclear how this addresses the issue. I think you need to consider giving them some if this further information before seeking the second consent.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature): Rowan Reiss*
Student number: U1129027

Date: 02.03.2015

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- [ ] HIGH
- [ ] MEDIUM
- [X] LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: *Neil Rees*

Date: 19.02.15

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

APPENDIX E: Participant Information Letter

PARTICIPANT INVITATION LETTER

UNIVERSITY OF EAST LONDON
School of Psychology

Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
NAME: Rowan Reiss
U1129027@uel.ac.uk

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of Doctorate of Clinical Psychology degree at the University of East London.

Project Title

Constructions of Readiness for Therapy on Adult Acute Wards

Project Description

The aim of the study is to explore how clinicians, including clinical psychologists, psychiatrists and psychiatric nurses construct their practice in relation to the idea of their clients' readiness for therapy and the implications of these constructions on clinical practice in inpatient psychiatric settings. The study is interested in the use of language and how people talk about readiness for therapy. The study will focus on three main areas:

- How you understand the idea of the concept of readiness for therapy
- How people talk about readiness for therapy in your work and in services
- How the idea of readiness for therapy plays into decisions of who gets access to therapy

Participants will be asked to discuss this topic during an interview with the researcher. They will also be asked to participate in a method called memory work in order to gather data in closer detail. Interviews will last for 50-60 minutes.

Guidance on participating in memory work

You will be asked to write two memories in preparation for the interview: one about a particular time when you have made a decision about when someone was ready for therapy and another about time when you have made the decision that someone was not ready for therapy, and submit these prior to the interview with the researcher. These memories will then be discussed during the research interview. All memories will be anonymised for the interview. Please write in as much detail as you can remember about

it and please write in the third person. As guidance an example is provided below. This is a different subject but is to give you an idea of how memory work is done.

> *A further example of this can be found in Anne's memory, where she describes the process she goes through before seeking help:*
>
> *'There was no-one home and the lights were all off. She rang everyone with the sole intention of checking no-one was arriving home anytime soon. These phonecalls which lasted a few minutes each seemed to go on forever as she impatiently waited to go online. The room was cold as she entered and she shivered as she turned the computer on, partly in nerves, but also the room was colder than usual. She fetched her baggy cardigan which was comforting since it was baggy and did not show her true form and yet perversely made her look fatter, a confirmation of her incentive [.] She heated up as the discussion progressed, indeed she actually felt rather hot, maybe this was the crying, still she felt able to remove her cardigan (her armoury) and it felt rather symbolic of the moment.' (Anne, 35–40; 59–61)* [22]

The steps are as follows:

1. Write 1 to 2 pages about a particular episode, action, or event

2. Write in the third person using a pseudonym.

3. Write in as much detail as possible, including even what might be considered to be trivial or inconsequential.

4. Describe the experience, do not import interpretation, explanation, or biography. [23]

Confidentiality of the Data

The names of the participants will be securely stored in a location accessible only to the researcher. The interviews will be transcribed by both the researcher and an assistant, employed specifically for the purpose of transcription who will be required to sign a confidentiality agreement. All identifiable information including names, service names and locations will be anonymised both in the transcripts and in the final report. The Director of Studies will read anonymised interview data only. Upon completion of this study, all audio-recordings will be destroyed, however data may be retained, in the form of securely stored anonymised transcripts, in case of further development for the purposes of publication post completion of the study.

Location

The interviews will be held at a time convenient to you in a private room at your place of work.

---

22 McGrath, L., Reavey, P., and Brown, S. D. (2008). *The scenes and spaces of anxiety: Embodied expressions of distress in public and private fora.* Emotion, Space and Society 1: 56-64

23 Crawford, J., Kippaz, S., Onyx, J., 1992. Emotion & Gender: Constructing Meaning from Memory. Sage, London.

Disclaimer
You are not obliged to take part in this study and should not feel coerced. You are free to withdraw consent up until two months before the proposed submission date (May 2017). 'Withdrawal' will involve deciding not to participate in your research and the opportunity to have the data you have supplied destroyed on request. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation and to reconfirm consent on completion of the interview process. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr Laura McGrath, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email address l.h.mcgrath@uel.ac.uk
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Rowan Reiss

APPENDIX F: Clinical Vignette – Music Therapy

Before I started training to be a clinical psychologist and whilst working as a music therapist on inpatient wards and psychiatric intensive care units (PICU's), I had the privilege to meet David. An Afro-Caribbean man in his early-thirties David had stabbed his sister six years previously and had not spoken since. I met David on the PICU where I worked. He was highly anxious and still not speaking. He would remain in his room most of the time and when he did come out would slide along the corridors with his back to the wall and his hand over his mouth, visibly afraid. The multidisciplinary team's frustration with David's inability to, or choice not to speak was palpable. In meetings discussion revolved around how David's risk could possibly be assessed if he did not speak. One day I came onto the ward and learned that there was a plan for David to be given ECT. I challenged this and questioned why there was a move to give this treatment, recommended as a fourth-line treatment for intractable depression, to a man diagnosed with psychosis. Did the team think that he could be 'shocked' into speaking? When I started working with David he would not come to the music therapy room with me. I asked him if it would be ok for me to come and visit him once a week, to stand by the door to his room and spend some time with him. He nodded. After three months of visiting David each week, sometimes talking to him, sometimes remaining quiet, I asked him, not for the first time, whether he'd like to come to see the music therapy room with me. When he agreed I panicked: I hadn't expected him to agree and the room wasn't set up for a session. Nonetheless he came to the room and I then met with David for music therapy sessions for the next nine months. We worked purely non-verbally. Sometimes David would use the instruments, sometimes not. Sometimes we did some work around breath and breathing exercises and making small non-verbal vocal sounds. It was not perfect. Sometimes I got drawn into the dynamic of frustration expressed by the other members of the team. Feeling pressure to prove music therapy 'worked' and to produce a verbal result. This resulted in one memorable session where I must have looked visibly despondent and David tapped me on the arm and proceeded to "show me" how strong his breath was by blowing out all his air very rapidly. Six months later and I passed David in the hallway of the main psychiatric inpatient unit, a separate, open ward in the same building as the locked PICU. David saw me, waved, smiled and then carried on to wherever he was headed. He still, to my

knowledge, has yet to say a word but had been discharged from the PICU to the open ward and was eventually discharged into the community. Thinking back to that time now, as I come to the end of a doctorate which has equipped me further to think critically about clinical work, I have reflected many times on how much I learned from working with David: how teams can become frustrated and act in questionable ways if a patient does not ‘fit’ into their ways of working and the need to asses, how important it is to have time for trust to develop, the pressure to produce measurable ‘outcomes’, and how, whilst the format and outcome of therapy wasn’t what I might have expected, it was not for me as the therapist to judge what was meaningful and what was not to my non-verbal co-narrator.

APPENDIX G: Interview Structure

Interview structure and prompts

1. **Can you talk me through the two memories you sent me?**
   Prompts and follow up questions depending on content and responses but could include:
   - What made you select this particular memory?
   - Could you tell me a bit about the time when it happened? Who else was involved?
   - Were there many emotions around this memory?
   - How typical/not-typical is it?
   - How does it relate to other experiences you've had on this subject?

2. **Can you tell me a bit about what types of psychological therapies are available on the ward and what you think of them?**

3. **When do you send people to these different therapies? / Can you give me an example of a time when you've sent people to these therapies, and why?**

4. **What would be the typical reason you would send someone to psychology/psychotherapy.**

5. **What kind of therapies would you like to be available/what do you think is missing?**

6. **What does the concept of readiness for therapy mean to you?**

7. **Could you describe to me the process by which you assess/decide when/if someone is ready for therapy?**

8. **Can you talk me through what kind of things you think about when deciding?**

9. **Could you give me an example of a time when you've decided not to proceed with therapy?**

10. **Do you discuss these decisions with the team/referrer?**

11. **What views/ideas/factors do you think impact those clinical discussions/decisions?**

12. **How do you discuss this idea with other professionals?**

13. **Are there groups of patients who are more likely to be not ready/ready for therapy in your experience?**

14. **In situations where people are deemed not ready how regularly are they reassessed?**

Further prompts:

- I was interested in what you just said about xyz, can you tell me a little more about that?
- How did that make you feel?
- Is that something that happens a lot?
- Are there times when the opposite happens?

Summarise and check but do not interpret: "Is this what you meant by that?".

During talking about the research and consent
Make clear that you're looking at language and how people talk about readiness for therapy.
How people understand the concept of readiness for therapy or how people talk about it in your services. And how this idea plays into who gets to access therapy.

Recording: Dictaphone

APPENDIX H: CONSENT FORM

CONSENT FORM

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ
The Principal Investigator(s)
NAME: Rowan Reiss
U1129027@uel.ac.uk

Consent to participate in a research study

Constructions of Readiness for Therapy on Adult Acute Wards

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..…….

APPENDIX I: TRANSCRIPTION CONVENTIONS

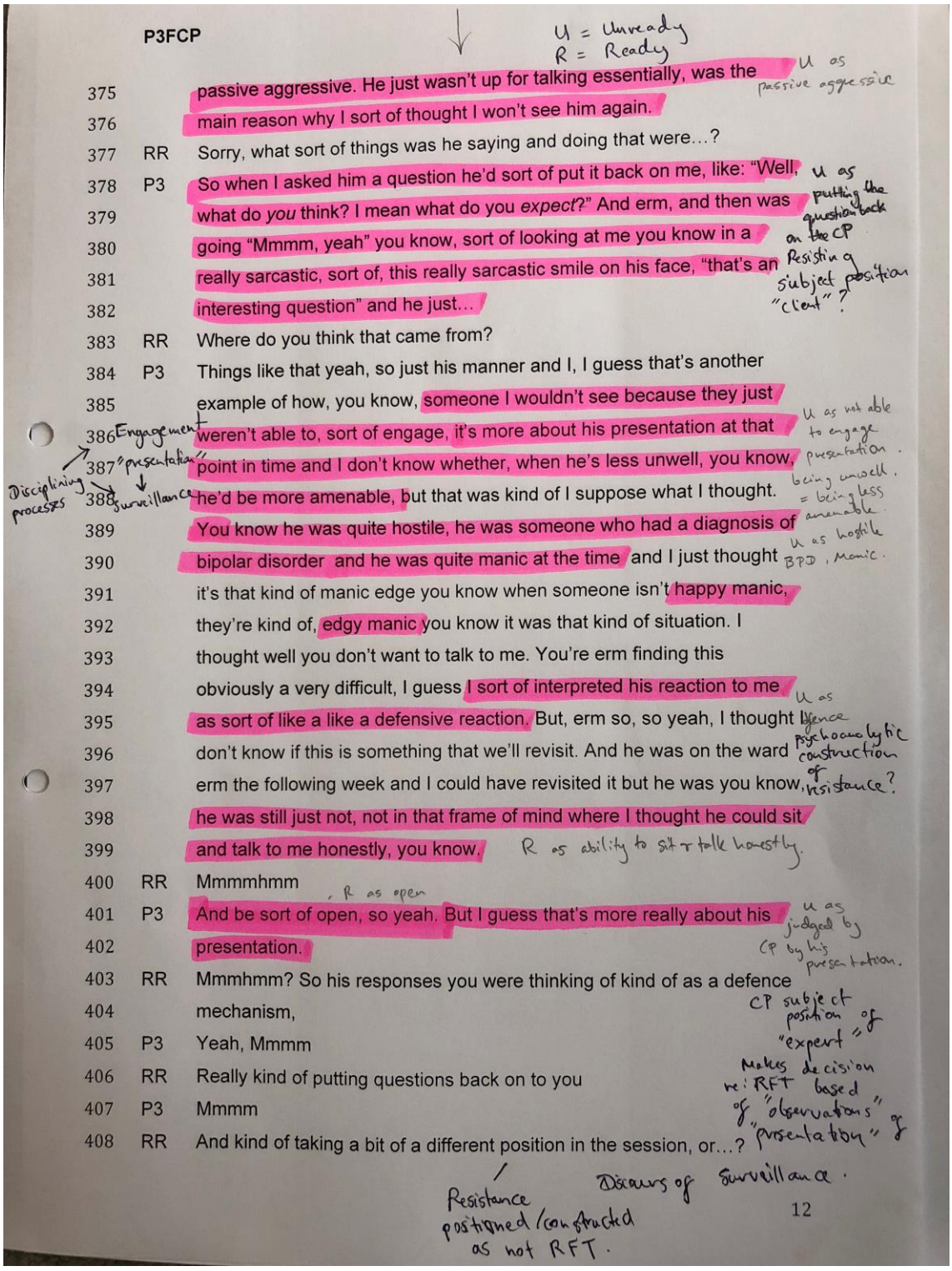
(.)	Indicate a pause of less than 1 second
((x))	Indicate a pause of more than 1 second, with x replaced with the number of seconds e.g. 3 seconds as ((3))
{LG}	Laughter
{LS}	Lip smack
{BR}	Intake of breath
::	Emphasis and/or exaggeration of letter sound e.g. not::
-th- (+there)	Indicates a breakoff of utterance e.g. th-Indicates a breakoff of utterance, where reasonable guess can be made of the intended word
(())	Unintelligible speech
XXX	Replace any place name to preserve anonymity
mhm/mmm/eh	Sounds transcribed phonetically
PX	Participant followed by a number to denote which participant e.g P6 = participant 6
RR	Interviewers initials

APPENDIX J: STAGES OF ANALYSIS

Stage of Analysis	Description
1. What is being constructed?	This stage involves a thorough exploration of the discursive object as per the research question.
2. How is it being constructed and problematised?	What are the different constructions that are presented in the data? What discourses are drawn upon to make these constructions possible? How are constructions problematised? (Problematisation refers to the construction of the discursive object as 'problematic' and, thus, knowable and visible. The problematised discursive object is a product of the intersection of alternate discourses. They reveal knowledge/power relations.
3. Functionality of the construction	Questions are asked of the data, which include; How is the discursive object being made a problem? What actions can be achieved through the different constructions of the discursive object? How do these discourses problematise function?
4. Identification of discursive subjects	This stage requires the consideration of the subject positions available resulting from the different constructions of the discursive object.
5. Processes of subjectification	This stage involves a exploring the implications for subjectivity; what can be experienced as a result of assuming various subject positions. It is concerned with the relationship between discourse and subjectivity. As discourses make available "certain-ways-of seeing the world, and certain-ways-of being in the world" (Willig, 2008, p.113), they can be said to construct social and psychological realities. Once having assumed a subject position as one's own, a person is constrained to see the world through the lens of that particular position. .
6. Technologies of power and implications for social practice	As discourses warrant social action, what can be done, said and gained from within different discourses and different constructions of the discursive object at particular points of the text? What are the different 'technologies of power/self' evident in the text and how are they used.

(Adams, 2016)

APPENDIX K: VISUAL REPRESENTATION OF THE CODED TEXT



P3FCP

U = Unready
R = Ready

375 passive aggressive. He just wasn't up for talking essentially, was the
376 main reason why I sort of thought I won't see him again.
377 RR Sorry, what sort of things was he saying and doing that were…?
378 P3 So when I asked him a question he'd sort of put it back on me, like: "Well,
379 what do *you* think? I mean what do you *expect*?" And erm, and then was
380 going "Mmmm, yeah" you know, sort of looking at me you know in a
381 really sarcastic, sort of, this really sarcastic smile on his face, "that's an
382 interesting question" and he just…
383 RR Where do you think that came from?
384 P3 Things like that yeah, so just his manner and I, I guess that's another
385 example of how, you know, someone I wouldn't see because they just
386 weren't able to, sort of engage, it's more about his presentation at that
387 point in time and I don't know whether, when he's less unwell, you know,
388 he'd be more amenable, but that was kind of I suppose what I thought.
389 You know he was quite hostile, he was someone who had a diagnosis of
390 bipolar disorder and he was quite manic at the time and I just thought
391 it's that kind of manic edge you know when someone isn't happy manic,
392 they're kind of, edgy manic you know it was that kind of situation. I
393 thought well you don't want to talk to me. You're erm finding this
394 obviously a very difficult, I guess I sort of interpreted his reaction to me
395 as sort of like a like a defensive reaction. But, erm so, so yeah, I thought I
396 don't know if this is something that we'll revisit. And he was on the ward
397 erm the following week and I could have revisited it but he was you know,
398 he was still just not, not in that frame of mind where I thought he could sit
399 and talk to me honestly, you know.
400 RR Mmmmhmm
401 P3 And be sort of open, so yeah. But I guess that's more really about his
402 presentation.
403 RR Mmmhmm? So his responses you were thinking of kind of as a defence
404 mechanism,
405 P3 Yeah, Mmmm
406 RR Really kind of putting questions back on to you
407 P3 Mmmm
408 RR And kind of taking a bit of a different position in the session, or…?

U as passive aggressive
U as putting the question back on the CP
Resisting a subject position "client"?
Engagement
"presentation"
Disciplining processes
Surveillance
U as not able to engage presentation. being unwell. = being less amenable.
U as hostile BPD, Manic.
R as ability to sit + talk honestly.
R as open
U as judged by CP by his presentation.
Defence Psychoanalytic construction of resistance?
CP subject position of "expert" =
Makes decision re: RFT based of "observations" of "presentation" of
Discours of surveillance.
Resistance positioned/constructed as not RFT.
12

Appendix K: Memory Work: The Method

The following is a description of the procedural steps as used by Crawford et al. (1992). The procedure has been subsequently adopted by most, but not all subsequent work in Australia and New Zealand. Phase 1 concerns the writing of a memory. The five basic rules (from Haug et al., 1987) are as follows:

1. Write 1 to 2 pages about a particular episode, action, or event (referred to by researchers as a trigger or cue).

   The writing of the memory has a number of benefits. It provides a discipline for the group, the group remembers more through writing and it gives the everyday experiences of life a status, which is considered of particular importance for women.

2. Write in the third person using a pseudonym.

   The advantage of writing in the third person is that the participant can create personal distance, and view the memory from the outside. This helps to avoid justification of the experience.

3. Write in as much detail as possible, including even what might be considered to be trivial or inconsequential.

   By asking for the trivial, it is hoped to avoid an evaluation by the participants of what was important or unimportant. Such an evaluation might well be socially defined.

4. Describe the experience, do not import interpretation, explanation, or biography.

   Interpretation smoothes over the rough edges and covers up the absences and inconsistencies that are crucial elements of the analysis. The selection of a suitable trigger topic is vital, but difficult. In particular, a conventional topic is likely to produce a conventional, well-rehearsed response. The trick is to produce the more jagged stuff of personal lived experience.

Phase 2 also proceeds through a set procedure (as identified in Crawford et al., 1992, p. 49):

1. Each memory-work group member expresses opinions and ideas about each written memory in turn.
2. The collective looks for similarities and differences between the memories. The group members look for continuous elements among the memories whose relation to each other is not immediately apparent. Each member should question particularly those aspects of the events that do not appear amenable to comparison, without resorting to biography.
3. Each member identifies cliches, generalisations, contradictions, cultural imperatives, metaphor, etc. This is one way of identifying the markers of the “takenfor-granted” social explication of the meaning of recurring events.

4. The group discusses theories, popular conceptions, sayings, and images about the topic, again as a way of identifying the common social explication of meaning around the topic.
5. The group also examines what is not written in the memories (but that might be expected to be). Silences are sometimes eloquent pointers to issues of deep significance but are painful or particularly problematic to the author.
6. The memory may be rewritten.

This collective analysis aims to uncover the common social understanding of each event, the social meanings embodied in the actions described in the written accounts, and how these meanings are arrived: The collective reflection and examination may suggest revising the interpretation of the common patterns, and the analysis proceeds by moving from individual memories to the cross-sectional analysis and back again in a recursive fashion. . . . In this way the method is reflexive. It generates data and at the same time points to modes of action for the co-researchers. (Crawford et al., 1992, p. 49)

In Phase 3, the material provided from both the written memories and the collective discussion of them, is further theorized. This phase is essentially a recursive process, in which the insights concerning the “common sense” of each set of memories is related back to the earlier discussions and to theoretical discussions within the wider academic literature. Phase 3 is usually done by one of the coresearchers as an individual (academic) exercise, though with drafts of this process subject to further discussion by other members of the collective.

(Onyx & Small, 2001).