WHAT CONTAINS THE CONTAINERS? AN ORGANISATIONAL THEMATIC ANALYSIS WITHIN AN NHS TRUST INVESTIGATING WHAT SUPPORTS STAFF IN THEIR WORK WITH PEOPLE ATTRACTING A BORDERLINE DIAGNOSIS

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This research was carried out in collaboration with Anonymous Partnership Trust

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ABSTRACT

People diagnosed with borderline personality disorder experience a 'double dose' of suffering. The chronic emotional pain and inner turmoil that is the result of their condition, compounded by stigma and prejudice at the hands of NHS staff they approach for help (Bodner et al., 2015; Dickens, Lamont & Gray 2016a). Interventions at an individual staff level have proven ineffective, with researchers suggesting further research might better target organisational and structural levels (Dickens, Hallett & Lamont, 2016b, p.125).

This insider research (Brannick & Coghlan, 2007; Crociani-Winland, 2018) builds on my experience working in one NHS Trust, across a variety of roles over an 8 year period. It takes a broadly ethnographic approach to a sequence of eleven interviews with staff working with borderline patients across the Trust, though in different teams, roles and having different professional socialisations. Interviews were analysed at individual and organisational levels, using a psychodynamic ontology (Armstrong, 2005; Hinshelwood & Skogstad, 2000; Hollway & Jefferson, 2013) & thematic analysis (Braun & Clarke, 2012) to provide a 'binocular' psychosocial synthesis (Richards, 2019). Data were triangulated with researcher observation and counter-transferential material. New knowledge is presented about what supports staff and teams to remain relationally connected to borderline patients, rather than detaching or becoming overwhelmed, when prejudice and stigmatisation become more likely.

Findings

At the individual level, the concept of therapeutic-level 'containment' was operationalised from theory and applied to the interview material. This was contrasted with the less therapeutically informed 'coping status', to form a continuum of containment. Higher level, therapeutic 'containment' was found to exist relatively independently of organisational factors, while lower level 'coping status' was strongly supported by organisational factors.

Contained staff relied on a superordinate process to sustain therapeutic-level relationships with patients. This process involved: 1. the capacity to manage inter-psychic proximity- the 'empathic adult' position', and 2. the capacity to

tolerate relational pain, attacks and not knowing- ‘negative capability’ (Bion, 1984). This key process was supported by a number of factors: a history of personal therapy, or experience of therapist-led group supervision; staff actively working to achieve ‘managed hope’; control over exposure to patients through informal spaces & supervision, and transitional frameworks drawn from professional socialisations (Bell,1990 [Main, 1966]; Winnicott, 1953).

At the group level, some teams were traumatically organised, while others functioned better. Interestingly, teams could be traumatically organised while seeming to cope well internally, through the use of social defences such as ‘barricading’, that pushed disturbance back out into other teams and patients. Traumatic team organisation could be mitigated by the organisation via managers, supervisors and wider organisational culture, through: reduced caseload sizes; providing theoretical frameworks; not passing on trauma from higher levels in the organisation, and giving staff control over exposure to the work through informal spaces, balanced with access to expert supervision.

This research suggests that Trust implementation of a manualised, time-limited intervention to help overwhelmed care coordinators was an organisationally containing act, supporting staff ‘coping status’ and protecting patients from the extremes of staff stigma & discrimination. However, insufficient funding meant the programme did not give staff sufficient time to reflect on feelings generated by the work. In this way, the programme functioned as a psychosocial bridge between social policy and staff internal functioning, inadvertently codifying emotionally dissociated ways of relating to themselves and others that discouraged therapeutic-level relationships. These treatment priorities may express and import a wider, market based culture of narcissistic self-reliance, where value is not attached to inner experience. In conjunction with atheoretical systems of diagnosis, such short term, manualised interventions may lead patients to lose hope in the possibility of change, potentially increasing their risk of eventual suicide (Paris, 2004, 2019). Longer term, relational therapies underpinned by psychosocial formulations and ‘containing practice’ are needed if meaningful and humane treatments are to be achieved for this group.

TABLE OF CONTENTS

LIST OF COLOUR FIGURES Page no:

Fig. 1: Organisational map p.47
Fig. 2: Hierarchy of containment p.76
Fig. 3: Continuum of containment p.78
Fig. 4: ‘Merged’ overinvolvement by staff p.85
Fig. 5: ‘Cut off’ repetition of rejection by staff p.87
Fig. 6: ‘Containment’ of unconscious patient request by staff p.88

CHAPTER 1: INTRODUCTION

1.1 Introduction p.1
1.2 Diagnosis and terminology p.2

CHAPTER 2: LITERATURE REVIEW

2.1 Prevalence, risk & treatment pathways p.6
2.2 Staff attitudes & burnout p.7
2.3 Staff attitude interventions p.8
2.4 Protective factors p.8
2.5 Treatment goals & tolerating exposure to borderline affect p.9
2.6 Psychodynamic model p.13
2.7 Organisational social defences p.15
2.8 Trauma organised systems & containment failure p.16
2.9 Containment in therapeutic practice p.17
2.10 Observing organisations p.21
2.11 The organisation-in-the-mind p.23
2.12 The ‘defended subject’ p.24
2.13 Psychosocial research p.25
2.14 Reflexivity and insider research p.25

CHAPTER 3: METHODOLOGY

3.1 Rationale p.29
3.2 Aims p.29
3.3 Objectives p.30
3.4 Design p.31

3.5 Evidence for a psychodynamic ontology and epistemology p.33
3.6 Methods p.36
3.7 Ethical considerations of a defended subject paradigm p.41
3.8 Sample size and saturation p.41
3.9 Procedure p.42

CHAPTER 4: ANALYSIS & INITIAL DISCUSSION

4.1 How well do teams and the organisation function? p.46
4.2 Who is contained and who isn't? p.75
4.3 How do contained staff achieve this? p.83

CHAPTER 5: CONCLUSIONS

5.1 Critical discussion of findings p.115
5.2 Limitations of research p.127
5.3 Implications for counselling psychology & broader practical applications p.128

REFERENCES p.135

APPENDICIES

Appendix 1. Trust Collaboration letter p.147
Appendix 2. FREC ethics confirmation p.149
Appendix 3. Scoping email p.151
Appendix 4. Participant information sheet p.153
Appendix 5. Participant consent form p.155
Appendix 6. Demographics form p.157
Appendix 7. Moving-on Programme information p.159
Appendix 8. Recruitment and demographics p.161
Appendix 9. Examples of data across individual and group p.163
Appendix 10. Summary article P.181

CHAPTER 1
INTRODUCTION

1.1 Introduction

This work explores how we achieve better care for a particularly stigmatised and excluded group of patients. People diagnosed with borderline personality disorder experience great inner turmoil, that often becomes manifested in their external relationships, as they create frustration and hopelessness in friends and carers. Hard won successes are lost the very next moment and staff often do not hide their reluctance to engage in ‘yet another round’ of fruitless therapeutic attempts. Borderline patients therefore frequently experience a ‘double dose’ of suffering, their own internal suffering, followed by the prejudice and rejection of staff they approach for help (Bodner et al., 2015; Dickens et al., 2016a), leading to high eventual suicide rates for this group (Paris, 2004, 2019).

A recent meta-synthesis of qualitative studies focussing on borderline patients’ experiences of treatment and recovery (Katsakou & Pistrang, 2018) found:
(a) safety and containment, (b) being cared for and respected, and (c) focussing on change, were helpful treatment characteristics; while, (d) not being an equal partner was unhelpful, and (e) change was described as an open-ended journey.

Symptomatic improvement amongst borderline patients is now understood to be more ‘common and stable’ than was previously thought, with a majority achieving significant change over a 6 year period (Zanarini et al., 2003). However, this more hopeful picture from contemporary research is often not felt at the coal face of NHS practice.

Over an 8 year period working in one Trust, I experienced how otherwise skilled and empathic staff adopted rigid and prejudicial positions towards this patient group. However, I also saw examples of positive practice, of patience, resilience and care that stood out against this backdrop. I began to wonder what helped some staff to achieve this while others could not?

The following research first reviews the mainstream literature, noting its paucity and an absence of actionable finding (Dickens et al., 2016b), before going on to advocate for a psychodynamic methodology, to better explore what helps staff to do this work well. The work is broadly ethnographic, in that it relies on my insider, subjective experience working across roles in one NHS Trust, in conjunction with interview data and counter-transferential observations.

The research is located within the psychosocial tradition, attempting to look both towards the social & organisational on the one hand, and towards the individual intra-psychic and inter-relational on the other, with the aim of achieving some degree of binocular synthesis (Richards, 2019). Such research therefore combines a more top-down, theoretico-deductive approach, with a more bottom up, participant driven inductive approach, aspiring to develop a two way vision of the organisation and the lived experience of its practitioners.

The individual level epistemology is described in Hollway & Jefferson (2013) and relies on the ‘defended subject’ paradigm. The group-level analysis relies on the same ontology, though extends the epistemology through new assumptions. Patient trauma is understood as capable of being passed ‘up’ the organisation, through staff via parallel processes (Gleeson & Fairall, 2007), as well as ‘down’ from the potentially traumatised organization (Bloom, 2011; Evans, 2014), through staff and into patients. Implications for practice flow from the critical realist and qualitative allegiances of the ontology and methodology. So while the quantitative notion of generalisability is not meaningful, to consider ‘receptive generalisability’ and ‘utilisation value’ (Smaling, 2003) from the qualitative findings of this research is appropriate.

The research aims to understand what supports some staff to remain relationally connected, while others revert to pushing patients away. It seeks to make recommendations regarding how to improve patient care, reduce stigmatisation for these patients and reduce burnout for staff.

1.2 Diagnosis & terminology

The terms Borderline Personality Disorder (BPD) (American Psychiatric Association, 2013) & Emotionally Unstable Personality Disorder (World Health

Organisation, 2016) are often used interchangeably to identify a group of people with certain shared characteristics: difficulty managing overwhelming emotions, fear of rejection and abandonment, difficulty forming and sustaining relationships, acting impulsively and who present a chronic risk of self-harm & suicide. These categorical taxonomies of the DSM-5 and ICD-11 are underpinned by an atheoretical, biomedical disease 'model' that is controversial, with professional guidelines (BPS, 2013) calling for paradigm change given the lack of reliability and validity of this system. With this guidance, the British Psychological Society formally acknowledged what researchers and professionals had long stated, that diagnosis within such systems stigmatises, disempowers and fails to take note of the literature on psychosocial aetiologies (Agrawal et al., 2004; Bentall, 2004; Bradley & Western, 2005; Cuthbert & Insel, 2013; Lyons-Ruth, 2002), or Recovery perspectives (Horn et al., 2007; Ng et al., 2016).

While some service users reported relief at receiving a diagnosis, 'finally having an explanation' (Horn et al., 2007; Stalker et al., 2005), many found diagnosis unhelpful, feeling it led to their being stereotyped by professionals (Nehls, 1999; Stroud & Parsons, 2013); that is was a 'dustbin label' (Horn et al., 2007); that 'treatment deteriorated as a result of the diagnosis' (Crawford, 2007) and that 'the diagnosis had no purpose in guiding treatment' (Nehls, 1999; Stalker et al., 2005).

Empirical research exploring mental health professionals' reactions to diagnostic labelling, found that practitioners who were given more information relating to a personality disorder diagnosis, reported significantly fewer reasons to be positive, in comparison to two other groups who weren't given as much diagnosis specific information (Lam et al., 2016). Similarly, a recent survey of psychiatrists (Sisti et al., 2016) found a majority had either withheld or not documented a diagnosis of borderline personality disorder, citing stigma as the main reason for this omission.

One service user explained:

> “You get this diagnosis and they say, “Well, we don’t believe hospitalization is very good and there isn’t anything pharmaceutical… there’s evidence that shows that it doesn’t help this population.” And I [say], “What can you do?” They say, “I’m afraid there’s nothing; you’ll have to help yourself”
> (Nehls, 1999, p.290).

A recent Consensus Statement endorsed by Mind, the British Psychological Society, the Royal College of GPs, the Royal College of Nursing, the Anna Freud Centre and the British Association of Social Workers (Lamb et al., 2018) argued that the ‘label of personality disorder was controversial and needed to change’. The authors note that when speaking about the people their paper concerns, they always meant people *given* a diagnosis of personality disorder, and never that they *were* that disorder. Throughout this work I adopt a similar convention, never meaning to imply that people given this diagnosis *are* their diagnosis. In this thesis, at times I use phrases like, ‘people given a borderline diagnosis’ to highlight this distinction, whereas at other times I revert to shorthand like ‘borderline patients’ or ‘BPD’, though only to improve readability.

I choose to use the term ‘patient’ rather than ‘service user’ or ‘client’ throughout this work. This could be viewed as similarly controversial, importing a biomedical conception of illness as secondary to disease. However, there is a need to identify someone as having a particular sort of difficulty for which they are seeking ‘help’, ‘therapy’ or ‘treatment’ and when the use of the word ‘person’ can be misleading. In this work I therefore adopt the convention of using the word ‘patient’, taking this to denote a psychosocial conception of the person. This is preferred by a majority of people accessing services (Dickens & Picchioni, 2012; Simmons, Hawley, Gale, & Sivakumaran, 2010) and could potentially be ‘reclaimed’ through a contemporary, non-biomedical usage by counselling psychologists.

CHAPTER 2

LITERATURE REVIEW

This literature review draws on a wide range of theory and research relevant to the topic studied. It is separated into three parts that track the development of my thinking in addressing the research questions:

Part one – 'borderline personality disorder and its treatment in psychiatry and the NHS', starts by reviewing more traditionally mainstream, quantitative approaches, laying out their language and the empirical limitations of this line of enquiry. The final sub-section of this part (2.5) introduces a new way of thinking about the area, using: 1. psychodynamic constructs, and 2. an organisational approach, that complements and problematises a purely individual-level analysis.

Part two- 'psychodynamic and organisational approaches', introduces some of the history of psychodynamic thinking in relation to this patient group (2.6), before expanding the model into organisations (2.7 and 2.8). The concept of 'containment' is briefly elaborated upon at individual, group and organisational levels (2.9) before an initial method for researching organisations is offered (2.10).

Part three – 'reflexivity and psychosocial research', offers a second method for researching organisations (2.11), a complementary psychodynamic research paradigm (2.12) and an overarching psychosocial research tradition, that goes some way towards holding the individual to organisational-level tension of the methodology together (2.13). Lastly, a reflexive statement is provided and the critical realist epistemology considered (2.14).

Part 1: Borderline personality disorder and its treatment in psychiatry and the NHS

2.1 Prevalence, risk & treatment pathways

Prevalence of BPD is estimated at around 0.7% in the general population and 4-6% in primary care. In inpatient settings, across all subtypes, personality disorder accounts for 50% of presentations, with BPD being the most common (NICE, 2009). Studies place the risk of eventual completed suicide between 3-10% (NICE, 2009; Paris, 2004, 2019), with threats peaking in the 20s and a mean age of completion between 30-37yrs (Paris, 2019). Paris suggests we take hope from this, noting “borderline patients do not usually kill themselves when they most alarm therapists, but later, if they fail to recover, or when a series of treatments have been unsuccessful” (Paris, 2004, p.240-241).

Long-term inpatient treatment is not recommended (Howe, 2013; Linehan, 1993; NIMHE, 2003; Paris, 2004). Regressive dependence tends to occur, with self-harming behaviour leading to closer nurse supervision that positively reinforces self-destructive behaviour in a downward spiral (Linehan, 1993). Despite an intention to only use inpatient services to manage acute episodes (Howe, 2013), a lack of alternate specialist ‘personality disorder’ provision (Crawford, 2007; Lamb et al., 2018; NIMHE, 2003) often means people with a borderline diagnosis are ‘treated at the margins’ (NIMHE, 2003) with lengthy, inappropriate inpatient stays being common (NICE, 2009).

Staff feel that this group should not be hospitalized (Bodner et al., 2015) and that inadequate care is too prevalent (James & Cowman, 2007). The strain on inpatient staff must be immense, as they are being asked to form therapeutic relationships in a context they know will only tend to make patients worse.

Psychiatrists find this one of the most challenging populations to work with (Howe, 2013), with research suggesting defensive practice may be common. For example, in one anonymous survey 85% of psychiatrists stated they had made decisions that were not in their patients best interests, but were primarily aimed at protecting themselves (Krawitz & Batcheler, 2006).

The legal status of personality disorder remains contentious, Jones (2009) arguing the failure to implement a new Mental Health Act, instead having to opt for the 2007 amendment, may be traced to resistance by many groups to the government seeking to include a legal power to pre-emptively incarcerate those with candidate personality disorders (Mullen, 1999). A high proportion of distressed men with traumatic histories attracting a personality disorder diagnosis will be found in the prison system rather than in hospitals (Conn et al., 2010; Skett & Lewis, 2019); while distressed women with traumatic histories will more often be represented in clinical research taken from NHS and specialist hospital settings (Katsakou & Pistrang, 2018).

2.2 Staff attitudes and burnout

Hinshelwood (2014, p.286) suggests, “The care of people who have defeated devoted loved ones and friends is bound to provide a greater challenge than most jobs”. Working in ‘personality disorders’ is personally and professionally demanding and burnout is high (Crawford, Adedeji, Price, & Rutter, 2010; Freestone et al., 2015).

There is no standard definition of ‘burnout’ (Edwards et al., 2000), although Maslach’s work (Maslach & Jackson, 1981) often forms the theoretical core (Holmqvist & Jeanneau, 2006). Maslach describes three elements of burnout:

1. No longer being able to ‘give of oneself’ at a psychological level,
    e.g. ‘I’m numb’, ‘I just don’t care’.
2. Negative, cynical attitudes towards clients,
    e.g. ‘they’re just manipulative’, ‘they know what they’re doing’,&
3. A tendency to evaluate oneself negatively,
    e.g. ‘I can’t do anything right’.

In the first of two contributions on the topic, Bodner and colleagues (Bodner et al., 2011) tested the emotional and cognitive responses of nurses, psychologists and psychiatrists to borderline patients. They found psychologists scored lower on antagonism than psychiatrists and nurses, while nurses scored lower on empathy than psychiatrists and psychologists. However, in contrast to psychologists and psychiatrists, none of the nurses reported any training on borderline personality disorder over the past two years. In a subsequent study, the largest of its kind at the time of writing, Bodner et al., (2015) approached 710 psychiatrists, psychologists, social workers & nurses, replicating the previous findings. All professions felt it was less justified to hospitalise borderline patients than depressed patients. Negative attitudes were positively correlated with caring for a greater number of borderline patients over the past 12 months.

A recent systematic review of 40 studies that explored the attitudes, behaviour and experiences of nurses towards borderline patients, found that nurses had consistently poorer attitudes towards this group (Dickens et al., 2016a). Nurses have also been found to be more socially distancing towards borderline patients, to perceive them as more dangerous (Westwood & Baker, 2010) and more in control of their behaviours (Dickens et al., 2016a; Horn et al., 2007; Markham et al., 2003).

2.3 Staff attitude interventions

Mainstream research has tended to focus on an ‘attitude problem’, implicitly suggesting it is something to do with nurses, perhaps being an educative problem. A systematic review of attitude interventions in this area (Dickens et al., 2016b) found that while some attitude changes were achieved, negligible empathic change was noted, even for an 18 month DBT training. The authors therefore questioned whether educational interventions were a suitable intervention target, noting poor results and the prevalence of structural barriers.

It may be that the level of analysis is wrong, with a focus on individual nurses obscuring important systemic & organisational drivers of these attitude and empathy problems. The methodology of my research seeks to address this possibility (see Chapter 3).

2.4 Protective factors

In the context of such widespread prejudice and stigma towards borderline patients, certain factors were found to support some staff to cope better. For example, having a therapeutic framework was associated with fewer negative attitudes and more positive ones (Hughes et al., 2017; Stroud & Parsons, 2013). Likewise, sharing a common outlook with team members helped to overcome ambivalence (Bergman & Eckerdal, 2000) and was also important to service users, who valued not having to keep repeating their story (Lamb et al., 2018).

Psychiatric ward staff frequently requested more training in therapeutic frameworks (Dickens et al., 2016a; Hughes et al., 2017; James & Cowman, 2007; Moore, 2012; Stroud & Parsons, 2013; Westwood & Baker, 2010) and more supervision (Crawford, 2007; Dickens et al., 2016a; Westwood & Baker, 2010). However, while some staff wanted more supervision and reported few opportunities, leaving them feeling ‘helpless and frustrated’ (Dickens et al., 2016a), others experienced supervision as a form of discipline that implied a problem in them (Moore, 2012).

Having greater experience was found to predict more favourable responses to borderline vignettes (Liebman & Burnette, 2013) and lower levels of negative therapeutic response (McIntyre & Schwartz, 1998). Strong team work, clear leadership and better opportunities for reflective practice also helped to protect staff from burnout (Crawford et al., 2010).

A particularly salient theme in the literature, also found in this research (Chapter 4, Section 4.3), was how practitioners struggled with feeling ‘unable to help’ borderline patients. Staff wanted to be ‘better at curing patients’ (Westwood & Baker, 2010; Woollaston & Hixenbaugh, 2008) and would become frustrated at consistently being ‘prevented’ from helping, leading them to feel hopeless and then reject these patients.

2.5 Treatment goals & tolerating exposure to borderline affects

Unhelpfully replicating a biomedical disease model’s conception of treatment goals by trying to ‘cure’ patients, may be part of the problem here. On such an understanding, if a patient doesn’t ‘get better’ and probably quite quickly, the staff member may feel they have failed at their job, placing patients at greater risk of rejection and stigmatisation by staff. However, if instead of seeing symptoms as things that must be removed, they are understood as meaningful communications about unmet developmental needs, then treatment goals can change quite radically, as can the notion of what being ‘productive’ and ‘successful’ in the work involves. This has the potential to reshape how staff experience patients and forms the theoretical core of an applied psychodynamic way of working.

From a psychodynamically informed perspective, borderline suffering is fundamentally about early relational trauma. The self-tormenting, internal worlds of borderline patients were acquired long ago at the hands of early caregivers, and their sabotage of current relationships is a somewhat paradoxical, unconscious attempt to replay this early scene, hoping for a better outcome (Fonagy et al., 2004; Freud; 1950). Freud developed the idea that our unconscious mind underpins much of our motivation for behaviour, but is hard to know and so is identified through associations, transference and repeated cycles of behaviour in the present. Fonagy and colleagues have developed Freud’s work, integrating contemporary psychoanalytic thinking, with developmental theory & the philosophy of mind to achieve a reformulation of attachment theory, together with a clear specification of targets for therapeutic change. Within such frameworks, the practitioner’s relationship to the patient becomes the real focus of the work. Surviving this relationship may be a significant part of the work for staff and patient alike, as the patient will unconsciously test staff, in an attempt to repeat their early experiences, though with some part of them hoping for a different outcome.

On such an understanding, the goal of treatment isn’t rapid change in someone’s external behaviour, but gradual movement in their internal world, that may only slowly show signs of external change. A rock climbing metaphor may be helpful. While some climbing routes are physically easy and feel psychologically ‘fine’, others are just as easy but feel terrifying, due to various hard to pin down factors. These include things like the rock angle, what is (or isn’t) beneath you, and the surroundings. So, for example, you could feel overexposed on a buttress, hanging in three dimensions with nothing around you; or feel more secure on a gently sloping slab, surrounded by reassuring surfaces.

The emotional and psychological challenge of working with borderline patients involves a similar kind of hard-to-pin-down, quality of exposure, that those not working in this field may similarly struggle to grasp. The necessary simple moves and techniques for working with someone’s distress can suddenly feel impossible to remember, as rising exposure to a person’s affective projections takes over one’s capacity to think. Or, the same simple moves and techniques can feel challenging, but fine, given increased levels of experience, or suitably supportive surroundings.

Part 2: Psychodynamic & organisational approaches

2.6 Psychodynamic model

As the previous section attempted to outline, the way we understand and experience ‘reality’ is powerfully influenced by the conceptual lens, or paradigm we view things through (Kuhn, 1970). Psychodynamic theories presume psychopathology needs to be understood in its developmental context, with the therapeutic relationship being the most important medium through which to understand and modify relational dynamics and emotion regulation capacity (Bradley & Western, 2005, p.927; Schore, 2003a).

A core task in psychodynamically oriented work with people who have Borderline Personality Organisation (Kernberg, 1975) is therapeutic ‘containment’. Though for successful containment work to take place, staff must first be contained themselves in order to be containing for their patients (Evans, 2014; Hinshelwood, 2014). Hinshelwood (1991) traces the concept of containment back to Klein’s (1946) work on projective identification, as developed by Bion (1959). A core idea is that babies will insert meaning into their mothers through a nonverbal, affective mechanism called ‘projection’, in order that the mother may understand, ‘process’ and then return back digested parts of experience that are now more manageable for the baby. Through time this process of emotional exchange is internalised by the baby and is known as ‘containing’, allowing it to develop a secure sense of itself as ‘someone’, with a rich and manageable emotional world and positive expectations about caregivers and future relationships.

The early caregivers of people who later attract a borderline diagnosis are theorised as having been ‘unavailable, unpredictable or frightening’ (Bradley & Western, 2005). Instead of containing their babies anxieties, they [unintentionally] contributed to their dysregulation (Lyons-Ruth, 2002). These toddlers may have learnt to ‘defensively protect themselves from recognising the hostility, or wish to harm them that was sometimes in their caregiver’s mind (Agrawal et al., 2004, p.2). As adults, this distortion manifests as an impaired ability to read others' minds and intentions (Anthony Bateman & Fonagy, 2010), leading to chaotic, fractious relationships and an inability to develop secure, adult relationships that might otherwise be a source of emotional soothing (Schore, 2003).

Understood through this model, the 'borderline patient' will repeat their search for containment of their most disturbing affects, resorting to the same preverbal, unconscious processes the child used with its early caregivers, unconsciously splitting off parts of experience that are too difficult to manage and then inserting them into staff through processes of projection and projective identification (Hinshelwood, 2014).

One of the first descriptions of these processes and the patient group was written by Tom Main, while working at The Cassell Hospital (Main, 1957 reprinted in Main, 1989). The Cassell Hospital was set up in 1914 to work with 'shell shock' victims of the first world war and Main worked as its Director from 1948-1978. Main and colleagues started to reflect on the impact a certain sort of patient seemed to be having on their staff team:

> *"Despite out of the ordinary efforts by nurses, the patients continued to not improve and the nurse felt they had 'failed as a person', if they had known more, tried harder, been more sensitive, the failure would not have occurred. The feeling ran side by side another- a resentful desire to blame someone else…for the failure" (p.16)*

Main and colleagues identified many of the characteristic challenges that those working intensively with borderline patients will know well. They highlighted the 'sentimental appeal' and 'arousal of omnipotence' the patient could elicit in the favoured nurse, who 'came to feel they had special abilities her colleagues lacked and would start to protect the patient from unwelcome routines and staff' (Main, 1957 in Main, 1989, p.22). Feeling 'irresistibly needed' by the patient and sometimes the therapist too, they would 'take more and more responsibility for the patient, to the point that the patient stopped taking any responsibility for themselves' (p.23). Patients were indulged with ever higher dosages of medication than was recommended and a concerned nurse’s attempt to convince the patient to accept less, would be quickly reversed by the patient calling the doctor until ‘vast doses were given daily’ (p.24-5).

Main described the way two languages developed, one framing the patient as ‘getting away with it’ (the out-group), the other that she was finally ‘showing the true extent of her illness’ (the in-group). The out-group described the in-group as collusive and over indulgent, whereas the in-group described the out-group as insensitive and oppressive (p.26). These patients, sensing the unacknowledged tensions between the two sides of the staff group, made ever greater attempts to seek ‘evidence of the reliability and tolerance of the in-group’. The increasing pressure on the in-group caused them to become more concerned and stressed, leading the patient to panic further, sometimes becoming aggressive and self-harming (p.26). In more contemporary language, what this is describing is the process of ‘splitting’.

The Cassell Hospital is currently based in West London and still runs as a therapeutic community underpinned by psychoanalytic principles. One of the research sites studied in this thesis - the specialist therapeutic community (STC) was modelled on it and is described in more detail below (Chapter 4). It is in these kinds of hospital organisations that people with personality disorders are treated as having mental health needs; while those with similarly disruptive and abusive early developmental histories, but who break laws or who present a risk to others, tend to be located in prison organisations. The latter will be disproportionately male (Clark, 2020) and almost exclusively receive ‘punishment’, rather than therapeutic intervention.

2.7 Organisational social defences

Psychoanalytic theory provides a diverse lexicon of ontological tools with which to understand and articulate the reciprocal relationship dynamics taking place between borderline patients and their carers’. As noted above (Section 2.3), to focus only on the individual-level may be unduly pathologizing and miss important causal information. To achieve a more three dimensional, binocular understanding we must move beyond the individual level, to incorporate structural and systemic factors too.

Object relations psychoanalysts made early contributions to research that applied psychoanalytic theory to groups, institutions and societies (Green, 2018). They observed how staff could unconsciously contribute by constructing social defence systems, when there was a lack of containing leadership. Menzies-Lyth (1960) observed unusually high levels of staff anxiety in a teaching hospital. She understood nurses' own deep anxieties as being unconsciously added to by the demands of both patients and hospital management, leading staff to create social norms as a kind of defence against anxiety, for example: 1. splitting up the nurse patient relationship through regular staff rotations; 2. using depersonalisation to achieve relational distance, "the liver in bed 2"; & 3. detachment and denial of feeling, "a good nurse doesn't mind moving'" (Menzies-Lyth, 1960, p.443-7).

In this study the individuals had become unwitting participants in a group process that might better be understood as belonging to the organisational level. Staff didn't have access to the forums they needed to be able to voice and work through their understandable anxieties, allowing unconsciously constructed social defences to survive. This lack of containment by the organisation, was in turn passed on to patients, who became secondary victims, through the impersonal and detached care they received from socially-defended staff.

2.8 Trauma organised systems & containment failure

At the chronic end of organisational containment failure, are trauma organised systems. In much the same way that people can become traumatised when exposed to repeated, abuse and maltreatment, so too can entire organisations (Bloom, 2011). Bloom invokes the concept of parallel process, explaining that 'individuals, groups & organisations that work closely alongside one another can develop similar affects, cognitions and behaviours' (p.141). The organisation is seen as having the potential to develop similar dysfunctional coping strategies as a person might, robbing the organisation of its human resource assets (Kahn, 1979), for example: dissociation & organisational amnesia; increased authoritarianism; disempowerment of employees; learned helplessness, and the silencing of dissent (Bloom, 2011).

Organisational members are exposed to projections from multiple directions, with front line workers having a greater potential for exposure. They must directly manage borderline projections flowing into them from patients ‘below’ and rely on the organisation to help them contain these. If the organisation has also become traumatised, then not only do staff fail to receive the containing support they need from ‘above’, but also receive the traumatised projections from ‘above’ of their would be containers. They are attacked from above and below in a kind of pincer movement.

This is the kind of situation that may have occurred with Mid Staffordshire Trust. In his report into the serious failings at Mid Staffordshire Foundation Trust, Francis felt a core problem was “a culture focussed on doing the system’s business, not that of the patient” (Francis, 2013, p.3-4). Rather than managers helping to contain their staff the reverse became true, as managers “pushed their anxiety about survival down the hierarchy into front line clinicians”. (Evans, 2014, p.194). With nothing left to protect themselves, staff resorted to primitive defences, unconsciously splitting off parts of themselves that might otherwise have been able to empathically resonate with their patients’ distress. Evans reflects that chronic shortages in the health care system underpinned this crisis and that structural issues need to be attended to if similar failures aren’t to be repeated (Evans, 2014, p.194).

2.9 Containment in therapeutic practice

Individual-level containment

From a psychodynamic perspective, the ‘healthy therapeutic relationship’ isn’t as straight forward as it may appear in other approaches. The patient is understood as bringing unconscious expectations about ‘relationships in general’ to the therapist, with the therapist’s task being to notice and understand these expectations, whilst not conforming to them (O’Hara, 2013). In this way the therapist, or staff member in an organisation, is understood as being ‘used’ by the patient. The therapeutic task is to understand what is being ‘put into’ them. The degree to which the therapist is able to remain empathic, consistent and stable over the long term, generally not becoming lost and overwhelmed by the patient's unconscious demands, is a measure of their capacity to contain.

Good containment includes:

1. A deep empathic connection, where the therapist can 'hold' and 'tolerate' the patient's experiences, including their pain, by 'suffering with' it (Bion, 1962). This is registered both consciously and unconsciously by the patient (O'Hara, 2013).

2. Not acting to try to end the difficult experiences through trying to 'solve' them (Casement, 2005). Instead providing growth promoting conditions, or a 'holding environment' (Winnicott, 1960), in which the patient changes as and when they are ready.

Part of the therapist's role is therefore suffering with the patient's not getting better immediately; thereby, not imposing the therapist's need for the patient to improve. Hence, containment is generally not about 'solving' problems through activity, though activity may nonetheless be present (Gold & Strieker, 2001). It is rather that the therapist must be vigilant that activity is not engaged in to manage the therapist's anxiety, rather than being in the service of the patient (Casement, 2005; Lemma, 2008).

Therapeutic communities & group-level containment

As introduced above (Section 2.5; 2.6 & 2.9), projection is a ubiquitous process we are understood to all engage in (Wachtel, 2017), though is particularly marked in people with borderline organisation. In therapeutic communities (TCs) that work with borderline patients, it is common for staff to develop strongly held, opposing views in relation to the same 'community member'. These 'splits' are theoretically predicted and numerous daily group reflective spaces are created to try to understand and 'process' splits through this framework. Staff are understood to take on different parts of the person's split projections (based on some pre-existing personal affinity). They may feel strongly impelled to 'act' based on these feelings, though are encouraged to wait and bring these urges to regular reflective spaces throughout the day

(Hinshelwood, 1987; Main, 1989; Nativ, 2014). Such spaces are seen as an integral part of the approach and are designed to serve the function of ‘containing’ the staff, wherein these projected feelings are explored and understood rather than ‘acted out’. The staff reparation processes are thought to involve the ‘digestion’ of these hard to process, split off parts of patients and through staff resolution are fed back to the patient in their more tolerable form (Hinshelwood, 1987, 1991; Main, 1989; Main, 1977; Nativ, 2014). This work of containing the team, is facilitated by having an external person who has not been present in the community throughout the day. Their mind therefore remains more open and unfilled by both the unconscious and the practical demands of community members. Their more neutral position, allows them to support the team to do this difficult processing work.

Haigh offers a related way of thinking about containment in therapeutic communities, suggesting the group may become a secondary site for ‘primary emotional development’ to take place. Primary emotional development requires: attachment, containment, communication and inclusion; qualities that were missing from the early developmental setting for borderline patients. Such qualities can deliberately be recreated in therapeutic communities, forming a structure for “secondary emotional development” (Haigh, 2013). In therapeutic communities, the group-level is often prioritised over the individual-level. So, rather than ‘the problem’ continuing to be seen as residing in the individual, it instead becomes a shared problem for the group to solve. All are affected by it; all are involved in thinking about how to work with it. The therapeutic community approach has also been found to positively support staff resilience (Bowen, 2013).

Organisational-level containment

In Menzies-Lyth’s (1960) hospital study, social defences were understood as somewhat contributed to by downwards projections from anxious leaders. Menzies suggested better containment of nurses could be achieved through structural changes, including supporting nurses to develop closer relationships with named patients and giving them spaces to work through their difficult, mixed feelings towards patients. Lawler (2009) considers Menzies-Lyth’s original study to have ‘passed the test of time’, with much of the thinking contained in it now being taken for granted through initiatives like having ‘key workers’ and acknowledgement of the personal impact of caring for ill people. However, he observes service level change hasn’t been reflected at policy level, with senior policy makers still prioritising targets over the quality of care. He suggests practitioners on the ground remain split off from the policy maker level.

Long (2018) described how leaders could support staff to reflect on a defensive culture, thereby helping contain staff to function better. She offers the metaphor of the ‘pack leader’, who must adequately manage their own anxiety so as not to trigger fear in others. Over time the leader learns to alternately listen to themselves and to their staff, to transition smoothly between using decisive authority and listening collaboration. Long is not hopeful about wider causes that might allow for deep change. She notes change will often be superficial, with conditions external to the organisation remaining untouched as ultimate causes. James (2007) similarly implicates ‘capitalist values’ and the loss of meaningful connection to the self and others as a cause of misery and distress for millions in our consumer culture. Likewise, Bollas (2018) traces a gradual denial of our internal world through the history of the last 200 years, replaced by technology, leaving fragmented selves prone to depression and anxiety.

Lucey (2018) makes similar points to Long, stressing how the social defence systems of organisations often reflect responses to external, societal pressures; in effect being a kind of psychosocial bridge between external society and internal organisational culture. Lucey describes her work in terms of supporting leaders have space to listen and think about their more difficult inner experiences. She notes such interventions remain limited to addressing symptoms, with the underlying societal cause of ‘unbridled capitalism’, remaining largely untouched. One consequence of these external pressures was suggested to be an increasing tendency towards narcissistic personality disorder within society more generally (Lasch, 1979), again linked with increasing levels of depression and anxiety in the population.

2.10 Observing organisations

Hinshelwood and Skogstad (2000) suggest that “in order to prevent or solve problems within organisations, one needs not only to address the conscious elements but also to understand the unconscious aspects” (p.v). They describe themselves as following the Tavistock tradition, taking Bick’s (1964) original method of mother-infant observation as their starting point, which they trace back to Trist ([1950] in Trist, Murray, & Trist, 1990), Jaques (1953) and Menzies-Lyth (1960).

Hinshelwood and Skogstad (2000, p.17, cited in Hollway & Jefferson, 2013, p.164) suggest the work of observing organisations is similar to the work of psychoanalysis, in that both include:

1. Evening hovering attention without premature judgement;
2. Use of subjective experience (sharpened as much as possible by personal psychoanalysis);
3. Capacity to reflect and think about the experience as a whole;
4. Recognition of the unconscious dimension;
5. Informed interpretation.

However, a point of divergence between organisational observation and therapy, is an inability to use patient feedback from interpretations offered in therapy to verify or falsify organisational hypotheses. The Observing Organisations approach therefore relies more on the capacity of the researcher to notice their experiences in relation to the organisation, based on having honed skills in this way of working, together with personal therapy within the tradition.

In this research I have used this kind of awareness, drawn from my insider role in the Trust, to develop an innovative aspect of the method that I apply to data interpretation. This helps to think about the place of the organisation in the respondent’s stories and to be specific about containment occurring along a continuum, that is at once organisational and personal.

Part 3: Reflexivity and psychosocial research

2.11 The organisation-in-the-mind

Another way of thinking about the health or otherwise of the organisation, is through the workers' constructions of it in their minds, or their organisation-in-the-mind. Sometimes referred to as 'the workplace within' (Hirschhorn, 1990), this construct picks out the way members of the organisation construct internal representations of the organisation, partly in response to their own defensive needs.

Hutton, Bazalgette and Reed (1997) propose the organisation-in-the-mind is a kind of bridge, or transitional object (Winnicott, 1953), through which the worker attempts to manage contact between their internal world and external organisational life. As such, it is subject to the vicissitudes of other internal objects, including the potential for parts to be denied or suppressed when they are too difficult to be consciously know. The role of the organisational consultant becomes to help the person bring these previously excluded parts back into awareness, so they can form a more accurate, albeit more disturbing, representation of the real organisation, allowing them to make better decisions.

Armstrong (2005, p.6) moves this idea on a stage further, suggesting that not only do individuals contribute to the organisation by constructing internal transitional objects, but they are also 'contributed to' by the organisation. If the organisation is traumatised, then this trauma will enter the inner world of the worker to become part of their 'organisation-in-the-mind'. One may therefore work with the person's inner representations of the organisation, to better understand something about the organisation externally, in a kind of inductive, reverse engineering.

Armstrong's (2005) method for accessing the participant's organisation-in-the-mind, shares many similarities with Hinshelwood and Skogstad's (2000) method of organisational observation. Armstrong prioritises the same psychodynamic principles (see above, Section 2.10; Armstrong, 2005, p.1-11), though introduces a new premise that 'everything taking place in the [interview] setting should be viewed in relation to the hypothesis of the experiential reality of their organisation-in-the-mind, with no interpretation of the personal inner world of the client being made' (p.8). So the difference in approach between inducting the organisation-in-the-mind of the worker, and making an organisational observation, lies mostly in the intended object of inquiry, and whether one is making judgements about the participant's constructions, or attempting to notice one's own constructions in order to take account of these when making organisational observations.

2.12 The 'defended subject' paradigm

Hollway and Jefferson (2013) deploy the concept of anxiety at the level of the individual through their construct of the 'defended subject'. This holds that people are constituted *relationally* and continually engage in processes of identification, projection and introjection' (p.x). Their psychodynamic ontology is committed to the ideas of:

1. The non-unitary, defended subject;
2. The psychoanalytic insistence on a dynamic unconscious, &
3. The idea that subjects are constituted relationally and continually engage in processes of identification, projection and introjection.

As noted above (Section 2.10), the challenge with such research is differentiating the researcher's own defended contribution from that of the researched. Hollway and Jefferson suggest ways of portioning out what is more personal from what originates more in another. They cite Hinshelwood & Skodstadt's (2000) approach (described above: Section 2.10) as well as that of Lucey, Melody, & Walkerdine (2003). Noticing the researcher's contribution to the relationship and separating this out from the participant's contributions, may be supported by keeping a careful reflexive journal of transference and countertransference observations, completed as contemporaneously to the interviews as possible and which is subsequently returned to on multiple occasions for consideration during data analysis (Hollway & Jefferson, 2013). The input of a trained supervisor also supports differentiation of unseen contributions (Jervis, 2009), as does personal psychoanalysis (Hinshelwood & Skogstad, 2000; Money-Kyrle, 1956). Returning to the material on multiple occasions over an extended period of time also helps ensure qualitative rigour (Hollway & Jefferson, 2013; Smith, 2015; Yardley, 2000).

2.13 Psychosocial research

The psychosocial research tradition (Clarke & Hoggett, 2009; Cummins & Williams, 2018) attempts to integrate disparate ways of looking at and understanding a topic, drawing on both psychological and social approaches. What unifies an otherwise disparate field of approaches is an attempt to achieve ‘binocularity’, where one may simultaneously look in both directions to try and develop a more nuanced, true to life description of a complex psychosocial picture (Richards, 2019).

The current research is located within the psychosocial tradition, attempting to look both towards the social & organisational on the one hand, and towards the individual intra-psychic and inter-relational, on the other. Such research therefore combines a more top-down, theoretico-deductive approach, with a more bottom-up, participant driven inductive approach, aspiring to develop a binocular vision of the organisation and the lived experience of its practitioners.

Jones (2009) analyses personality disorder in its historical context, to argue it is truly a psychosocial category. He cites Fonagy et al’s (2003) work on mentalisation, that locates the capacity to recognise and work with one’s own and others’ emotional worlds as fundamentally developing in ‘good enough’ early relationships. This psychosocial conception of mentalisation is consistent with modern relational psychoanalytic theory and practice flowing from the British Object Relationalists, Interpersonalists and Self Psychologists, being fundamentally rooted in an inter-psychic, ‘two-person’, conception of therapeutic work, rather than the intra-psychic, ‘one-person’ emphasis of earlier Freudian and Kleinian models (Seligman, 2003).

2.14 Reflexivity & insider research

Working across various patient facing roles in one NHS Trust over an extended 8 year period, was a formative part of my development as a clinical practitioner. Part of the way through this period I was accepted onto the Doctorate in

Counselling Psychology at the University of the West of England and this research idea started to form.

My position in the Trust was often ambiguous, with multiple roles meaning I never quite fitted the context. Initially, I was more clearly an ‘insider’ within psychology, where I fully identified with a band 4 assistant psychologist role in forensics. However, for a longer period of time following this I was more of an ‘outsider’ to any singe team, working as a lower graded band 3 doing bank work shifts on the inpatient mental health wards, in the crisis team, in the eating disorders service and finally, in the specialist therapeutic community (STC) for personality disordered patients. I was offered a part-time, permanent post at the STC and continued in this role for 1.5 years, leaving in my final year of training to focus on study. During training I was also on placement one day a week, working as an honorary band 6 psychotherapist, both in this Trust and in one other.

The overarching theoretical orientation of the STC was relational psychodynamic and this was also the core modality for my training and therapy practice. I found this framework very helpful in thinking about and working with psychological material. I currently identify as a practitioner who draws heavily on applied psychodynamic theory in addition to other models and approaches, such as cognitive behavioural therapy, systemic work, social constructivist and social inequalities thinking.

The use of researcher subjectivity has a long history in qualitative research (Braun & Clarke, 2006; Clarke & Braun, 2013; Drapeau, 2002), as well as in anthropology (Upadhya., 1999), ethnography (Hegelund, 2005), psychosocial studies (Clarke & Hoggett, 2009; Cummings & Williams, 2018) and organisational consultancy from a psychodynamic perspective (Armstrong, 2005; Hutton et al., 1997). The use of subjectivity is generally viewed negatively by positivists who see it as ‘unscientific’, though sits comfortably with critical realist and constructivist epistemologies for whom social reality is argued to be only partly knowable or multiply realised (Archer et al., 2016). Thus, while positivists seek to remove themselves from ‘contaminating’ what they see as an independently existing set of facts, making ‘insider status’ a confound to be controlled, the critical realist epistemology sees being embedded in the system as a valuable source of information about a partially knowable, partially constructed, psychosocial reality.

Insider research argues we are all embedded in multiple systems and this embedded knowledge is a valuable tool to be drawn on (Brannick & Coghlan, 2007). A psychosocial construction of insider research views one’s greater level of membership in the organisation as an asset. Deeper involvement in the organisation allows for richer connections to be made between individual staff accounts and the social circumstances that both they and the researcher share.

CHAPTER 3

METHODOLOGY

3.1 Rationale

Prevalence of stigma and prejudice towards borderline patients in NHS services is ubiquitous. However, while many staff struggle with borderline patients and inadvertently contribute to their secondary traumatisation, others are more resilient, robust and caring. How do the more resilient staff achieve this? The literature review noted how mainstream, positivist attempts to address this question had met with only limited success, further noting that a narrow focus on the individual-level may have obscured important structural level contributions (Dickens et a., 2016b). Psychodynamic and psychosocial methodologies were presented as alternative frameworks better suited to exploring these issues through their expanded ontological lexicon and capacity to look in multiple directions, connecting the individual-level and the group-level through a binocular, psychosocial focus (Richards, 2019).

My work in multiple roles across one NHS Trust over an extended 8 year period, provided valuable insights into how different parts of the Trust responded to borderline patients. As with the literature review, my experience in clinical practice was that some staff struggled greatly with these patients, while others were more resilient, caring and effective. Achieving a more holistic understanding of what supports staff to do this work well, may allow recommendations to be made that better support staff and teams in this work, reducing burnout while improving the therapeutic care for a particularly marginalised group of patients.

3.2 Aims

This research asks the psychodynamically framed question, ‘what contains the containers?’ (Bion, 1962; Ogden, 2004; Winnicott, 1960). The ultimate aim was to learn from examples of good practice, whilst also attending to staff who were struggling, in order to better understand what supported or hindered their capacity.

The research takes the literature review as its starting point, incorporating the recommendation that multiple levels of analysis should be attended to. It seeks to look in ‘both directions’: through a macro-zoom lens that explores individual-level, intra-psychic and inter-relational factors; as well as through a wide-angle lens that explores team and organisational-level factors. The psychosocial synthesis of these two ways of looking, is hoped to develop a more nuanced psychosocial understanding of how individual and organisation factors inter-relate to impact on staff containment and patient care.

3.3 Objectives

Objective 1

The first objective was to gain an impression of the relative health, or traumatic organisation of the various teams within the organisation, including how they related to one another and to the organisation. This is summarised in an organisational map at the beginning of the first analysis and discussion section (Section 5.1, Figure 1).

This objective focussed on teams through participant and researcher constructions of the organisation. It applied this ‘wide-angle’ lens, using a bottom-up analysis of participant material, supplemented by researcher observation.

The goals at this stage were to: socialise the reader to the life of the worker and the organisation; to offer a commentary on the possible organisation-in-the-mind of the worker; to offer an organisational observation made by the researcher, and to offer an initial judgment on how well the staff member was coping in the work.

Objective 2

The second objective was to establish which staff were ‘contained’ through a more detailed analysis of their responses. I applied psychodynamic theory relating to the concept of containment to answers that participants gave to questions about their experiences of working with borderline patients. This allowed me to develop a key conceptual framework and to venture a tentative placing of respondents along this continuum, from more to less contained, with examples to support this.

Objective 3

The third objective was to analyse the data of participants who were identified as more contained, in order to investigate how they achieved this.

The goals at this stage were twofold. Initially, an analysis that explored the macro-zoom, close-up level, looking for common thematic patterns & strategies used intra-psychically and/or inter-relationally by contained staff. The second analysis then applied a wide-angle, analytical lens, incorporating the findings of Objective 1 & 2, to look for higher-level explanations of staff containment flowing from team or organisational-levels.

3.4 Design

This research relied on eleven staff interviews, all of whom worked with borderline patients, though in varying roles and services throughout one Trust. Interview data were triangulated with insider organisational observations and counter-transferential material, to provide a qualitative, psychodynamic and psychosocial analysis of how 'contained' staff achieved this.

The individual-level epistemology is described in Hollway & Jefferson (2013) and relies on the 'defended subject' paradigm, with ontological commitments to: 1. the existence of the non-unitary, defended subject; 2. the psychoanalytic insistence on the existence of a dynamic unconscious, & 3. the idea that subjects are constituted relationally and continually engage in processes of identification, projection and introjection. The research accordingly views participants' responses as both partly known and conscious, but also partly unknown and unconscious. It is therefore an example of critical qualitative research (Clarke & Braun, 2013) in that it takes an interrogative stance to the data provided by participants.

The group-level analysis relies on the same ontology, though extends the epistemology through new assumptions. Patient trauma is understood as capable of being passed 'up' the organisation, through staff via parallel processes (Gleeson & Fairall, 2007), as well as ‘down’ from the potentially traumatised organization (Bloom, 2011; Evans, 2014), through staff and into patients. Teams within the organisation are seen as having a kind of independent agency, allowing them to unconsciously construct social defences when other containing structures or processes are absent (Menzies-Lyth, 1960). Defensive cultures and practices that exclude patients may therefore develop to achieve this; or, with better leadership and organisational containment, more open cultures and inclusive practices can equally develop (Lucey, 2018; Long, 2018) that remove the need for social defences. The team and organisational-level methodology is operationalised by methods of organisational observation (Hinshelwood & Skodstad, 2000) and a commentary on participants’ organisation-in-the-mind. (Armstrong, 2009).

Developing the themes was quite an embryonic process and the methodology came from sitting with the data. Broadly speaking, this involved reading it over and over, making tentative notes on individual transcripts, then across them, then finding some were more 'individual' and others more 'organisational', which became the tracks for how I took the analysis forwards. Some thematics, flowed from reading the transcripts to hear categories more from theory. Another level of thematics was more emergent and came from hearing people’s descriptions of how safe they felt and what they did to support themselves. Themes 1 and 2 (Section 4.3.1) are perhaps more ‘top down’, though equally flow from the data; while 3-6 are less theoretically informed, and more ‘bottom up’. I have quoted extensively from interviews to illustrate these different themes (Section 4.3.1).

The research thereby takes a critical realist stance, relies on a psychodynamic ontology and has a binocular psychosocial methodology. It is hoped the resulting synthesis of methods will provide a more nuanced description of the dynamics underpinning patient care, so that more useful clinical recommendations may be made.

3.5 Evidence for a psychodynamic ontology and epistemology

As part of my professional culture I have often needed to think about the nature and quality of 'evidence' with the dominant paradigm being hard to substantiate in terms of real world outcomes and practice. Such positivistic, mainstream constructions of 'evidence based research' have been used to undermine therapy, research and NHS commissioning. I briefly set out some of these problems as they have very much been part of the environment in which this research took place.

What constitutes 'evidence'?

The legitimacy of a psychodynamic ontology is sometimes questioned. Dispute tends to centre on its status as 'evidence based'; however, such questions generally flow from biased constructions of what constitutes 'evidence'. As Johnston (2017) notes, "one person's evidence is another person's fanciful mythology, and yet another person's propaganda".

Within psychotherapy research, the phrase 'evidence based' is no longer rooted in a scientific effort to integrate: a. clinical expertise, b. patient preference/values, and c. relevant scientific research. Instead it has 'become a code word for manualized therapy, most often brief, one-size-fits-all forms of cognitive behaviour therapy' (Limbus, 2014; Shedler, 2018, p.319). Worse than this, when the evidence for evidence-based treatments is closely inspected, most of the interventions are actually found to be **ineffective** for most of the people, most of the time (Shedler, 2018).

This paradox reflects a growing divide between the aims of academic researchers and therapy practitioners working with patients (Shedler, 2006):

1. Researchers tend to exclude the riskiest patients and those with comorbidities (Western et al., 2004). These are the very people that make up the bulk of clinical practice, meaning the "evidence" doesn't fit the context to which it will be applied.

2. The high cost of research means economic considerations, rather than clinical judgment, determines the length of therapies, with short term therapies tending to be tested over longer ones (Western et al., 2004). This means only certain brief manualised therapies are ever put through the testing process, and so evidence based therapies tend to also only consist of brief manualised ones. This stands in stark contrast to clinical practice, where longer term therapies tend to be the norm, reflecting a positively correlated dose-response curve (Lambert et al., 2001; Morrison et al., 2003; Seligman, 1995).

3. A further limitation is the process of manualization itself, that is almost always an artifact of the testing framework, rather than being assembled to reflect clinical need, or flowing from theoretical judgment. Manualization is used so that competing approaches can be tightly specified, reducing the influence of any extraneous variables in research frameworks (Western et al., 2004). Whereas, in clinical practice, flexibility and responsiveness to patient need, rather than manualization, are at the heart of good therapeutic practice (Dalal, 2018; Loewenthal, 2011).

In all these ways and more, the research paradigm doesn't fit the clinical picture of real world therapy.

The flaws inherent in transporting a Randomised Controlled Trial methodology from a medical context, into a psychotherapeutic one have long been known (Westen et al., 2004), but continue nonetheless. Shedler (2020) summarises what most clinicians working in private practice, or more forward thinking institutions have long known, "that for most people, six months of therapy is a starting point for meaningful change, and studies of therapies of 12 months or longer should be the norm". Research using more clinically realistic treatment time frames attests to this (Bateman and Fonagy, 2008).

That the dominant mental health research paradigm is more located in the dark ages than the 21st Century, is unknown to most lay people. It might seem implausible, for example, that NICE would refuse to consider looking at long term outcomes for cancer research, instead insisting only short term outcomes be considered. However, in mental health research this is what happens and successive governments have only paid lip service to addressing this lack of ‘parity of esteem’ (British Medical Association, 2020).

When writing an early draft of this work, NICE guidance for depression was awaiting republication after its third revision, following repeated & severe criticism from a coalition of stakeholders (Rost & McPherson, 2019) together with demands for a “full and proper review”. Criticism included: the lack of any long term data (a year or more) for a long term condition; failing to give equal weight to quality of life and functional outcomes, where these were of greatest importance to service users; failing to consider partial recovery from a more severe baseline, and failing to include a broader range of evidence beyond a narrow focus on symptom outcomes. Most of these recommendations have since been incorporated, however NICE resisted making any of these changes at every point, for some time.

The above considerations highlight the way contemporary constructions of “evidence” are contested. NICE’s partisan constructions of evidence in mental health, together with their misleading methodologies, would if published, have obstructed adequate care being commissioned for patients. The changes forced upon NICE by this coalition of stakeholders will mean more costly, longer term forms of therapy will need to be considered and commissioned. To what extent NICE’s constructions of evidence may be understood as serving economic and political ends, rather than being underpinned by a values of patient need (Carney, 2020), are perhaps pressing ethical questions worthy of further consideration.

Psychodynamic constructs

The ontology of a psychodynamic paradigm is articulated in constructs that go beyond the atheoretical symptom based diagnostic categories of the DCM and ICD classification systems, that are currently still required for research funding (Cuthbert & Insel, 2013; Insel & Cuthbert, 2010). This makes their inclusion in mainstream constructions of evidence problematic, in that they rely on a different explanatory framework.

The theoretical constructs of a psychodynamic framework are not in themselves controversial, (Western,1998); however, when a higher level description of them as ‘psychodynamic’ is used, the constructs are then seen as flawed. This may be an attack on an archaic ‘version of psychodynamic theory, that most clinicians would similarly consider obsolete’ (Western, 1988, p.333).

Randomised Controlled Trial evidence

Evidence from multiple independent, high quality systematic reviews demonstrate large effect sizes for psychodynamic approaches, comparable to those of other therapies (Shedler, 2010, p.98). A significant element of this finding was that as length of time since the end of treatment increased, so did the effect sizes. This pattern is significant in that it stands against the normal trend, where therapeutic gains tend to degrade over time (ibid, p.101-102). This reverse trend for psychodynamic approaches, is consistent with the idea that core processes of change are being initiated in psychodynamic therapy, that once started continue to gain momentum over time, even once therapy has finished.

Leichsenring & Klein (2014, p.4) provide further evidence for psychodynamic approaches, noting enduring benefits five years after the completion of therapy, with only 13% of participants meeting the previous diagnostic criteria from a Mentalisation Based group, as compared to 87% for the control group (Bateman et al., 2008). These findings may help to contextualise why clinicians tend to choose psychodynamic therapies for their own personal therapy (Norcross, 2005).

3.6 Method

Eleven interviews were conducted with staff from different services within one Trust. They were self-selecting, having responded to a scoping e-mail (Appendix 3). Interviews were conducted at five geographic locations and included workers from two community mental health teams (CMHT), a crisis team, an inpatient mental health ward, a specialist personality disorders service given the pseudonym the specialist therapeutic community (STC), and an experimental pilot site for a manualised intervention for CMHTs working with borderline patients given the pseudonym the ‘Moving-On Programme’ (Appendix 7).

Interviews followed a semi-structured format consisting of 7 questions, providing structure whilst giving participants flexibility in how they choose to respond:

Interview questions

1. How do you feel about working with people attracting the borderline personality disorder / emotionally unstable personality disorder diagnosis?
2. Working with this group of people is known to be particularly difficult. What helps you to ‘survive’ in this work?
3. Do you, or your workplace have a particular framework for understanding and working with people given this diagnosis?
4. Do you find supervision / reflective spaces useful in helping you think or feel about working with this client group?
5. What would help you personally in your work with this client group?
6. Given unlimited resources, what do you think might help people given this diagnosis?
7. Is there anything else you’d like to say or you think might be helpful for me to know?

Interviews were digitally recorded and then transcribed verbatim. Interviews were between 30 – 60 minutes long with the confidentiality of interviewees maintained throughout. The Trust’s identity has also been removed.

Research questions & methods

The following research questions were formulated from the rationale, aims and objectives:

1. To what extent are teams and the organisation functioning ‘well’ and how are they relating to one another?
2. Who amongst the staff are ‘contained’ and who are not?
3. (i) What individual level strategies or qualities allow contained staff to achieve this; and, (ii) what team or organisational strategies or qualities support contained staff to achieve this?

Initial Thematic Analysis with binocularity

The interviews were first analysed individually, using an adapted version of Braun & Clarke's (2006) Thematic Analysis. Thematic analysis is a versatile method, benefitting from being well specified in the literature and not imposing any particular theoretical framework. It instead provides a structural shell within which a theoretical core may be placed, in this case a psychodynamic ontology. Immersion in the data through extended familiarisation (Braun & Clarke, 2012; Clarke & Braun, 2018) was followed by multiple rounds of reflective reading some of which was shared with an external supervisor for their input and reflections. An emergent element of this process came from a more 'bottom-up' approach, while some of it was more formed through integration of the data with organisational and psychodynamic theory.

Following this extended process of orienting to the data, the following methods were developed to address the research questions:

Question 1 methods

The first question sought to understand team and organisational functioning. I relied on a tripartite framework, in order to approach this question from different angles. One part was a bottom-up analysis of the worker's construction of the organisation through their organisation-in-the-mind (Armstrong, 2009). Another part involved organisational observations (Hinshelwood & Skodstad, 2000) by myself as an insider researcher. The final part was providing an initial commentary on the participant's capacity to be fully present in the therapeutic relationship whilst at the same time being able to tolerate and think about this, or their 'degree of containment'. This triangulation of data sources was supported by external supervisory input, a journal of transference and counter-transference observations and personal psychoanalytic therapy. A summary of interrelationships between the teams is presented in an organisational map (Figure.1) that is expanded on in Section 4.3.2 (Organisational level theme- 'team exposure').

The analysis and initial discussion of these findings is presented in Section 4.1. They are presented in a transparent manner (Yardley, 2000) that is grounded in examples (Elliott et al., 1999), allowing the reader to interrogate the manner in which the conclusions were drawn to assess potential transferability through receptive generalisation (Smalling, 2003), together with their rigour, impact and importance (Yardley, 2000; Elliott et al, 1999).

The principles of: (i) researcher organisational observation and (ii) inferring the interviewee's organisation-in-the-mind are outlined in Section 2.10 and 2.11 respectively. Both involved relying on the use of: evenly hovering attention without premature judgement; subjective experience (sharpened as much as possible by personal psychoanalysis); the capacity to reflect and think about the experience as a whole; recognition of the unconscious dimension, and informed interpretation (Hinshelwood & Skogstad, 2000, p.17). The main difference between the two approaches lay in the intended object of inquiry. For organisation-in-the-mind assessments, judgements were made about another subjects' likely constructions of the organisation. While with organisational observations, the goal was to notice my own constructions, in order to better take account of these when making organisational observations rooted in personal experience.

Differentiating my personal transference contributions from those made by interviewees was supported by maintaining a careful reflexive journal of transference and counter-transference observations, completed as soon as possible after each interview. This was intended to help bring into awareness intersubjective, unconscious communication that paralleled the more surface, semantic content of the interviews. I included the input of a suitably trained supervisor to further help bring into awareness unseen personal contributions to interviews (Jervis, 2009). Disentangling personal transference contributions (Money-Kyrle, 1956) was further supported by ongoing, three times a week psychoanalysis as well as by returning to the data on multiple occasions over an extended period of time (Hollway & Jefferson, 2013).

Question 2 methods

The second question explored which workers were 'contained' (Bion, 1962; O'Hara, 2013; Schore, 2012; Winnicott, 1960) and was achieved through a more top-down, theoretically driven analysis of interview responses.

I felt I needed to first understand who was 'more contained' and who 'less contained' in order to be able to make any meaningful comments about what supported people to do this at individual and/or organisational levels. I applied psychodynamic theory to individual interviews, to develop a model of contained practice for these participants (see Section 4.2; Figure 2- hierarchy of containment, and Figure 3 - continuum of containment). Representative segments of text are presented to support judgements about where participants should be located along a continuum of containment, from 'contained' at one end, through 'coping', to 'not coping' at the other. This analysis takes account of any psychodynamic defences being used and the extent to which these predominate in the individual's functioning. The analysis is again presented in a transparent manner (Yardley, 2000), that is fully grounded in examples (Elliott et al., 1999) and was supported by the diary of transference and counter-transference responses triangulated with supervision input, personal analysis and returning to the data on multiple occasions.

Question 3 methods

The third question examined how participants judged to be contained in the previous section, achieved this. It relied on my application of thematic analysis (Braun & Clarke, 2012; 2018) to the interview transcripts of contained participants at multiple levels (individual and team/organisational), integrating other elements of the analysis so far, together with further theory.

Two ways of thinking about the data are highlighted through separate levels of analysis. They are separated out for clarity, but are nonetheless understood as reciprocally interacting throughout the processes that were researched and analysed.

1. One level (Section 5.3.1) explored individual, intra-psychic and inter-personal elements in order to highlight any strategies or qualities common to this group.
2. Another level (Section 5.3.2) focussed on the team and organisational elements and integrated analyses from the previous findings sections.

As with the ‘Initial thematic analysis with binocularity’ (above), immersion in the data through extended familiarisation (Braun & Clarke, 2012; Clarke & Braun, 2018) was followed by multiple rounds of reflective reading and theoretical integration, some of which was shared with an external supervisor for their input and reflections. Themes were considered in relation to the interview material in cyclical rounds of reading, analysing, rereading and reanalysing the data.

3.7 Ethical considerations of a defended subject paradigm

A criticism of psychosocial research from within a defended subject paradigm, might be its divergence from the face value representations of interviewees as compared to the researcher’s constructions of data, by including less conscious or unconscious observations.

Hollway and Jefferson (2013) cite ‘compassion’ as central to this kind of research, noting its widened conception of ethics. They invite us to consider a research participant who we dislike, explaining this is a relatively normal experience. They describe how within a defended subject paradigm, the researcher’s ‘othering*’* of this participant becomes a focus for exploration during the analysis. Thus, “to recognise these feelings and gradually become able to reflect on their origins and meaning for us as researchers, is part of the emotional work required for ethical practice” (Hollway & Jefferson, 2013, p.164-165). The approach therefore acknowledges that the researcher is also a ‘defended subject’, but one who is trying to understand and take account of their unconscious contributions. As opposed to viewing this methodology as a potential ethical problem, this form of research might rather be seen as striving to achieve an enhanced form of research ethics.

3.8 Sample size & saturation

Braun & Clarke (2006) suggest a suitable number of interviews for a ‘medium sized’ UK Professional Doctoral study is 10-20. Smith (2015) suggests a lower estimate of 6-15 interviews. The objective of this research was to achieve good ‘saturation’ (Glaser & Strauss, 1967), while ensuring sufficient space was available within the examined format to present the findings to a high standard, given the breadth of research ambition. I estimated that three rich interviews from staff with varying professional backgrounds (e.g. therapist; nurse; psychologist; psychiatrist; health care assistant; manager etc.) from each of four organisational contexts (e.g. crisis team/inpatient; psychology; CMHT; STC) would provide a sufficiently broad dataset from key practice areas across the organisation.

I received fewer expressions of interest from inpatient and STC contexts than I had hoped for, with the CMHTs being disproportionately represented. I decided to stop recruiting at 11 interviewees due to the volume of data already gathered (in excess of 100,000 words).

3.9 Procedure

Ethics

An NHS Trust provided authorisation for the research to be conducted on their premises on the 18th January 2018 (Appendix. 1) and ethical approval was granted by the Faculty Research Ethics Committee on the 27th July 2018 (Appendix. 2).

Scoping email

A scoping email was sent (Appendix. 3) via a Trust consultant psychologist to professional and team leads within the Trust. Expressions of interest came directly to my secure NHS email inbox.

Participant information sheet & consent process

A Participant Information Sheet (Appendix. 4) and copy of the Consent Form (Appendix. 5) were sent to people who expressed an interest on a ‘first come first served’ basis. Once a threshold for the number of people required for each profession and service area was reached, further expressions of interest were gratefully declined. It is perhaps noteworthy that a disproportionate number of care coordinators responded and that it was necessary to stop recruiting from this category at a relatively early stage. This may reflect how overloaded they were, together with their need for more support is a ‘wrung out system’ (see Figure 1 and Section 4.1: participants 1 and 10).

Interview venues and times were agreed with those who were happy to proceed having received the Information Sheet and Consent Form. At interview the consent form was discussed and signed, followed by the Demographics Form (Appendix. 6), at which point the interview was conducted, digitally recorded and subsequently transcribed by me.

CHAPTER 4
ANALYSIS & INITIAL DISCUSSION

Chapter four is comprised of three sections:

Section 4.1- provides an overview of the organisation’s health and functioning. Two organisational research methods are applied and an initial comment about participants’ level of containment is offered. Relevant participant data is provided to help socialise the reader to the life of the organisation and lived experience of its practitioners.

Section 4.2- addresses the individual-level question of who is more or less contained along a continuum of containment, comparing and contrasting this with ‘coping’ and ‘not coping’.

Section 4.3- analyses themes at two levels: individuals and organisational. Individual-level themes 1 and 2 (A. Superordinate process) offer a re-formulation and elaboration of contained practice from participant data. Individual-level themes 3-6 (B. Supportive elements) outline things that support or underpin this ability. One organisational-level theme, theme 7, is then presented and applied to the various teams outlined in the research and to a Trust wide intervention given the pseudonym ‘the Moving-On programme’.

4.1 How well do teams and the organisation function?

This first section of analysis provides: (i) a commentary on staff constructions of the organisation using organisation-in-the mind inferences; (ii) organisational observations by the insider researcher, and (iii) an initial commentary on staff ‘coping status’, that is developed further in the following section (Section 4.2: Who is contained and who isn’t?).

Possible dynamics within and between the various teams are summarised in an organisational map (Figure 1). These dynamics are developed further in a subsequent section of analysis (4.3.2: Overview of organisational-level theme) with a partial synthesis between organisational-level and individual-level themes being offered in the concluding section.

Teams are clustered into five parts of the organisation for this stage of analysis:
1. Trust Headquarters; 2. Psychology department; 3. Moving-On pilot site;
4. Remote CMHT, and 5. Specialist therapeutic community.

I summarise the upcoming section of analysis in the form of an organisational map (Section 4.1, Figure 1). Tentative relationships between the various parts of the organisation are presented, as are organisational observations (red) and organisation-in-the-mind inferences (green), that are elaborated upon below.

Organisational map

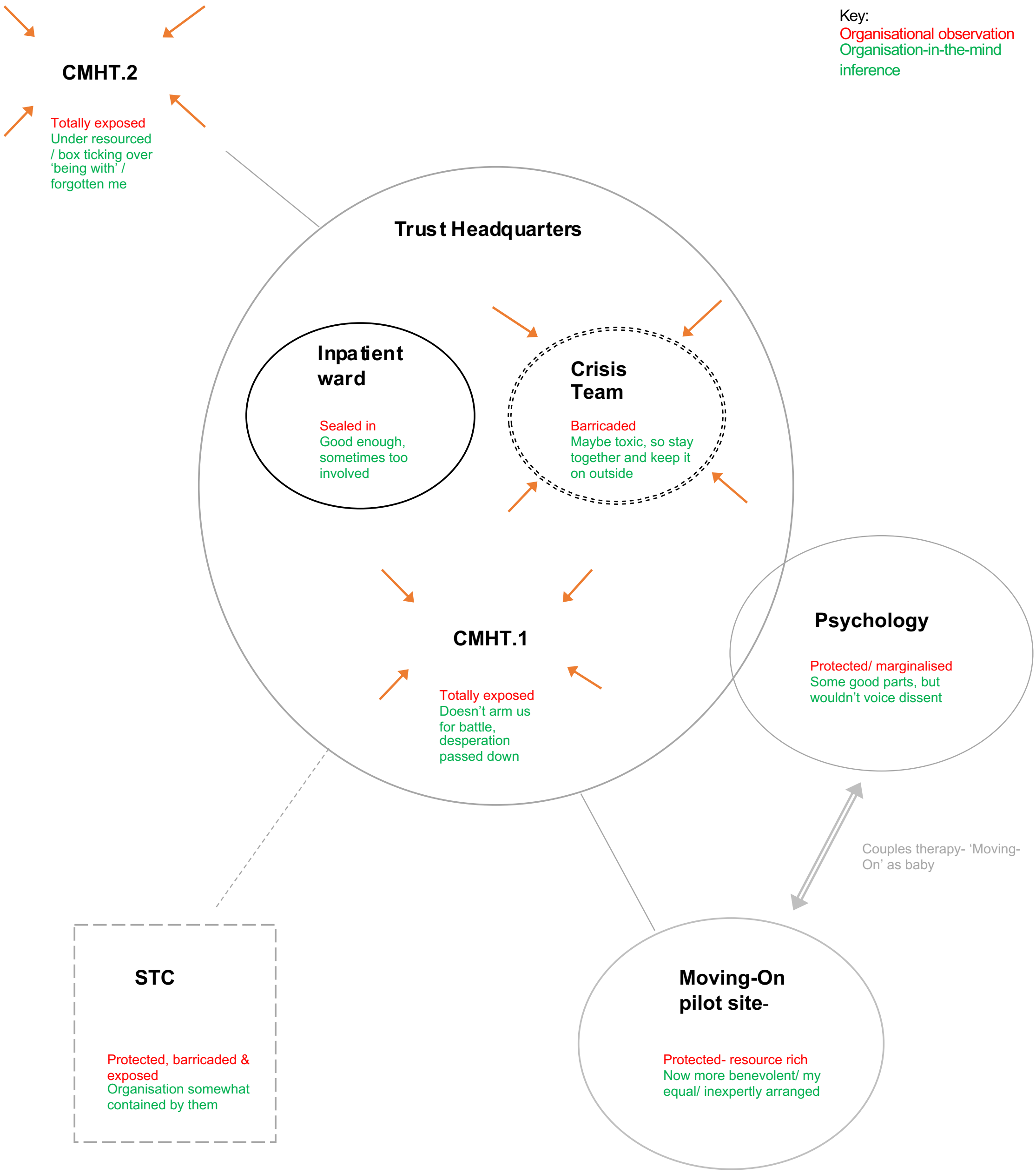

Figure 1 – Organisational map

4.1.1 Trust Headquarters

The first three teams were located at Trust Headquarters. Interviews were conducted with a care coordinator from a community mental health team (CMHT.1) given the pseudonym Simon; a nursing assistant from an acute inpatient mental health ward given the pseudonym Andrea, and a crisis team manager given the pseudonym Clare.

Organisational observation

Sharing a single geographic site linked these services. Designated staff from each team would hold site-wide alarms and the possibility of a response from across the site provided more of a sense of security than for teams on the periphery of the County. The atmosphere of the various clinical spaces remained idiosyncratic to the team and service constraints they operated within. This is the corporate headquarters of the Trust and walking across the grounds one had more of a sense of life taking place outside of clinical spaces. The site houses many of the Trust's inpatient psychiatric wards, all except for the specialist therapeutic community (STC) and older adult psychiatric wards, that are located on the periphery. Psychology is also 'not quite' on this site, being located on the general medical site some 10 minutes' walk away.

Participant 1. Simon: nurse, care coordinator delivering Moving-On

At interview Simon was friendly and articulate, though clearly stressed. He often refers to the Moving-On Programme (see Appendix. 7) - a newly implemented brief manualised approach to support overwhelmed care coordinators to work in a time limited way with personality disordered patients. It consists of an eight week intervention, with weekly group supervision by psychology. Psychology supervision is new for the community teams and very welcome.

- Note on transcription

During transcription I used capitals to indicate increased emphasis in the voice of the participant.

Simon repeatedly described ‘struggling with PD Moving-On’:

14. “This big change towards PD Moving-On. I DO STRUGGLE, I STRUGGLE with the sort of with the structure of it. . . I struggle with the structure, I I I struggle with certain personalities that come through the door”

He uses the metaphor of being at war, feeling “bombarded” and “not armed enough”:

32. “My issue is, you go on a two day course to tell you how to deal with these people, not deal with maybe, treat these people, but that doesn’t arm you well enough f f f ffff for the bombardment of the questions and the complex nature”

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59. “There are some really complex people that have waited a loong time for this and they’re exPecting Change and for you to come along and say ‘we’re doing an EIGHt Week intervention’ . . I just Don’t feel that I’m Armed enough.

He feels placed in an impossible position where he cannot meet reasonable patient expectations:

34. “People WAIT for so long for any for any sort of intervention. And then they get a nurse, a social worker an OT for 8 weeks (deeper inhale) and we’ve only had, two days training. . .it just feels so limited. At the end you can refer to psychology but it just feels like you’re putting off the inevitable really”

He feels “palmed off” and sees Moving-On as somewhat disingenuous, perhaps implemented by the Trust to get waiting lists down rather than meet patient needs:

213. “I feel we’re being palmed of with these complex people only to get the waiting list down and delay the inevitable really”

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271. “We need clear assessment when they come into the service, rather than being fobbed off with an eight week sticking plaster”

He feels Psychology could be more appropriately involved at an earlier stage:

231. “In an ideal world, my view is sit down, have a three way meeting with the psychologist, the client and then have a really good talk about what that person wants, what the psychologist can offer and what we can provide as care

> coordinators, rather than trying to palm somebody off with an eight week intervention”

> 255. “Eight weeks could be shortened to two sessions if there was a psychologist involved”

Simon vividly describes his position:

> 283. “And people just come to you, you know, just like armed with what they want to dump on you, so it’s an hour of of just ‘cttttchpoooooosh!’ listen to me this is my shit. Listen to me. You try and receive it in some sort of structured way. At the end of the day it’s their shit that you’re listening to and trying to put that into some sort of context which is very very very very very hard armed with the skills we’ve got.

After turning the recorder off Simon spontaneously tells me a story of a holiday to a coastal area in Europe, that I subsequently gained consent to use. He describes hearing a woman screaming from the rocks around the cove. He and his friends drive round to find five bodies floating face down in the water. A group of older tourists have been washed from the rocks, only two survive. What stays with Simon is the woman’s inconsolable cries as she contemplates breaking the news to their families.

This spontaneous story felt like an unconscious communication from Simon to me, about his precarious position in his role. He perhaps also feels ‘at sea’ and ‘at risk of drowning’. He may fear being in the woman’s position, where he must break unbearable news to the relatives of his patients.

Summary

Organisation-in-the-mind: Disingenuous, unsupportive. More concerned with waiting lists than people.

Organisational observation: There is a resources famine in the organisation relative to the level of need. Care coordinators are overexposed to this unmeetable need. They seem on the front line of a battle for survival, both their patients’ and their own.

Participant status: At sea & at risk of drowning, and so likely to occupy the uncontained end of the spectrum.

Participant 2. Andrea: nursing assistant, inpatient mental health ward
I knew the inpatient ward where Andrea worked a little from historic bank work shifts I worked there. The focus and tone of Andrea's interview was quite different from Simon's. The inpatient environment seemed to provide a degree of protection from the sea of unmet need externally. However, she was also 'sealed in' and couldn't easily walk away from her charges. It is visceral, up close work.

Andrea, like Simon, refers to a poverty of resources in the system:

> 43. "I don't feel hopeless but I'm not full of hope if you know what I mean. I don't know if there's enough services out there for the people that need them. There's a long long wait list"

She is positive about the work, though admits to challenges too. It can feel like "banging your head against a brick wall, as you're getting nowhere"; staff burn out because of "constantly mopping up blood and cutting off ligatures":

> 23. "I get quite a lot from that type of person, though my colleagues get quite frustrated… Sometimes it's a bit like banging your head against a brick wall isn't it, cos you're getting nowhere"
>
> -----------
>
> 145. "If we have a patient that comes in and they are particularly challenging, or there's a certain amount of staff burnout cos we've been mopping up blood and cutting off ligatures right left and centre, which can have a very negative impact. Although really, I think I'm desensitised to it all now if I'm honest, I'm no longer fazed by stuff like that"

A team approach seems more central to the inpatient context than the CMHT where Simon works, though difficulties may get located at group level. For example, while Andrea finds group supervision helpful, at other times she experiences it as an imposition:

> 221. "It normally turns into a bit of a moan fest, but in the midst of all that moaning and carrying on something great will be said and it will touch something within you & just make the work with someone a wee bit more bearable"
>
> -----------

> 246. “Sometimes you’re made to go. That’s not very nice. I don’t like being made to go to group supervision because sometimes I’m just not in the mood and I don’t want to listen to anyone winging and moaning about whatever and I don’t want to be winging and moaning either”

Sometimes, not talking is helpful. While at other times informal peer support is most important:

> 229. “We can access them [group supervision] weekly if we want to. I’m not always there to do that. Sometimes it can be a little like, ‘I just don’t want to talk about that person anymore’”
>
> -----------
>
> 253. “It can be equally important just to have peer supervision with each other in the staff room, you know like have a cup of tea and just go, ‘God! You know she’s driving me bloody nuts’, and sometimes that’s enough.

She describes a need for more psychotherapy provision for PD patients, while acknowledging the difficulty of working with people who aren’t ready for therapy yet:

> 345. “I think there needs to be more STCs [specialist therapeutic communities for PD patients], because there seems to be a hell of a lot more demand than supply… And I think ‘how do we manage people before they’re at a point where they’re stable enough to go to the STC?’ I mean you have these kinds of periods in people’s lives when there’s just nothing”

Andrea seems appropriately ‘at sea’ on a relational journey with patients and is mostly able to navigate this well. The organisation seems to provide sufficient support for her to do the work and sometimes even a little more than she wants, potentially containing splits that manifest within the group in an appropriately boundaried way.

Summary

Organisation-in-the-mind: Supportive enough, sometimes at risk of becoming authoritarian and dictatorial.

Organisational observation: Ward as a sealed container, little gets in or out, condensing team dynamics over external factors. Inside there is enough support to go around, while outside there is a resources famine.

Participant status: Appropriately at sea, mostly navigating well, and so headed towards ‘contained’ status.

Participant 3. Clare: nurse, crisis team manager

I also knew the crisis team from bank work shifts I historically undertook there. The practitioners seemed capable and autonomous. There was a clear culture that both respected individual approaches, but also held them together in overall outlook and approach. Staff retention was unusually high and people would frequently return to do regular bank work shifts there on retirement.

Despite my positive experience of working in the crisis team, I also found it to be one of the most stigmatising parts of the Trust for PD patients.

Clare starts by immediately acknowledging the use of labels that imply prejudice in her team, though notes this doesn't come from an uncaring place:

> 6. "I understand that some of my colleagues can be a little bit biased sometimes but I don't think that's in an uncaring way. I don't carry that point of view, I don't see the label I see the distress and what a person's presenting with"

She describes a dark sense of humour that binds the team together, though also has the potential to be viewed negatively by outsiders:

> 80. "We recently had a student with the team and she found it difficult to accept the humour that, well not taking the mickey out of service users, we would never do that, but some of the flippant comments that professionals DO make . . . It was explained to her that sometimes that's just a coping mechanism"

Clare feels part of the reason her team struggle with PD patients is 'not being able to help them', something particularly difficult given nurses 'task orientated' training:

> 173. "They find it very frustrating the amount of people that have the diagnosis that come through the crisis team. The sense I'm getting from them is that it's because they feel 'what can I do to help?' With schizophrenia or a bipolar diagnosis people tend to get quite well quite quickly. With this diagnosis it's very different"

> 447. "Cos nurses are task orientated in our thinking . . . the idea of long term models of working would require a whole shift of attitude"

Clare previously worked as a care coordinator, describing this as being very difficult. She notes the shared caseload was a big draw to the crisis team:

> 149. “I moved into crisis work because I’d had enough of care coordination. . . the amount of people you have on your caseload where you’re firefighting and risk managing constantly. . . I had three weeks off work through stress and I’m quite a level headed person, I don’t tend to get myself worked up that often. So for me to have time off with stress, I knew I had to do something different”

Clare knows the CMHT at Trust Headquarters are really struggling, whereas she feels relatively lucky:

> 539. “I know that colleagues over in the community teams have got major difficulties with recruitment… I’m in a really lucky situation and that helps me with my stress. Some people have been here a long time, a very long time.”

She describes the Moving-on Programme in a similar way to Simon, suggesting the Trust should invest properly in people with this diagnosis:

> 561. “I’m not gonna knock the Moving-on Programme, but 8 weeks? Sometimes it’s taken people a lifetime to come to where they are now. I don’t think anything can be undone is 8 weeks”
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> -----------
>
> 567. “I think we need to invest in people with a personality disorder”

While Clare describes supervision as essential, she and her team actually receive little:

> 266. “Supervision, I think it’s essential. I think it really is essential, it really is essential. You need it as a group when you’re working in the crisis team and we did have that but the person’s off sick at the moment”
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>
> 305. “I haven’t got a clinical supervisor at the moment”
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>
> 396. [Psychologist sickness absence] “A good 6 months. . . We’ve not really felt the difference actually”

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484. [Team supervision figures] “Quite low actually. I think there’s 3 or 4 band 6s have got clinical supervisors identified, that’s out of a total of 13”

In a similar way to the inpatient ward, the crisis team feels like an organisation within an organisation, in this case barricaded from outside influences like supervision. They are self-sufficient, working with a strong culture that retains staff, though is not well disposed to PD patients, who may be stigmatised.

Summary

Organisation-in-the-mind: Clare seems ‘on message’, making it hard to assess her constructions of the organisation. Implicitly, the organisation may be experienced as toxic by the team, requiring them to the construct social defences externally. Clare may be happy sitting somewhere between the ‘outside’ organisational arrangements and the team’s ‘inside’, well-functioning strategy.
Organisational observation: The crisis team seems barricaded, not allowing PD patients or the organisation in.
Participant status: Historically, Clare didn’t cope well as a care coordinator, where she was ‘at sea’ and ‘not coping’. She now no longer appears to be at sea with patients, instead perhaps choosing to remain in the dry dock with the rest of the team, where it is safe.

4.1.2 Psychology department, main medical hospital site

The fourth team was located at the second research site, the psychology department. One interview was conducted here, with a systemic psychotherapist given the pseudonym Paul.

Organisational observation

The psychology department was difficult to find, and therefore difficult to get into. It was also located on the general hospital site, rather than the mental hospital site, where its sibling services were located.

While staff from the mental hospital site could pay a nominal, monthly sum for a parking permit, psychology staff at the general hospital site could not. Central city parking was costly, though streets around the hospital contained a limited number of free, two hour spaces, leading the team to empty the building every two hours to rearrange their cars between these free spaces.

Psychology is sometimes seen as privileged, enjoying higher bandings relative to other professions. Psychology's positioning on the periphery, away from the mental hospital site could be seen through this lens as evidence of privilege. However, it could also be seen in the opposite way, as reflecting redundancy and marginalisation relative to the other professions. Psychology staff leaving every two hours to move their cars felt significant and to contain an element of active resistance by staff to the seemingly unequal organisational rules.

Participant 4. Paul: therapist, psychology department

I didn't know Paul prior to conducting this research and had no prior experience of the department. Some months after interviewing Paul I went on to work in this department as an honorary trainee psychologist, one day a week for 6 months.

While Paul historically found working with borderline patients 'very challenging', he now felt 'it's a privilege':

> 7. I think my attitude's changed a lot . . . I got more insight into what's actually gone on in people's backgrounds, which is often trauma related. So I actually feel it's a privilege to work with them now"

He sees ‘personality disorder’ as a label used by psychiatry to exclude patients they find it hard to build relationships with and feels society can behave in a similar way.

> 86. “I think it’s just a label anyway, personality disorder. . . it’s a convenient label often used in psychiatry, to label people who they are unable to build a relationship with, or who seem to be presenting with difficult behaviours”

There are a sequence of responses that suggest he experiences a level of fear in relation to the organisation. He initially notes ‘reflective spaces are important though limited, one must leave the building’ to find them:

> 274. “I think I need a lot of reflective space for myself, so I make a point of getting that and sometimes I walk out of the building to take space”

He then remarks on finding it hard to be open in supervision, hinting at a difficult relationship with the organisation in the past. He then draws this to a close rather abruptly, almost as though feeling paranoid he is being spied on:

> 278. “I don’t always feel supervision is offering what I would like . . . I think that might be something about my historical relationship with the Trust and the fear of, a fear basically of a… Historically I think the Trust has been an organisation that will, and I’m talking historically, will.. A lot of power games used to go on anyway, so you kind of become careful about what you say. I’m not going to say any more than that.”

Following this he praises his manager, and while this may be straightforwardly true, it is hard not to also read the sequence in a somewhat Orwellian manner, where praising his manager is a balancing attempt to make up for dangerous admissions about the shortcomings of the organisation:

> 296. “One of the things I would say about this team and I really value this, is if I wanted some support from my manager, I know I could just say look please could we chat and he would. And he’s very supportive, so I think it’s a very supportive team in that way”

Summary

Organisation-in-the-mind: The organisation may have some good parts, but it also feels dangerous to voice dissent or name its limitations.

Organisational observation: Psychology seems separate and somewhat protected from the rest of the Trust. However, this may reflect privilege, marginalisation or redundancy.

Participant status: Paul appears appropriately 'at sea' on relational journeys with his patients and to be coping well.

4.1.3 Moving-On pilot site

The Moving-On pilot site was the next part of the organisation to be considered and three interviews were conducted here, all from within one team. The interviewees were a care coordinator given the pseudonym Sue; a trainee psychiatrist given the pseudonym Angharad and a psychologist given the pseudonym Robin.

I didn't know any of the participants prior to the research, nor was I familiar with the research site. My scoping e-mail was responded to by the psychologist, who volunteered the other two participants.

Organisational observation

This was a unique research site in that it was a collaboration between psychology and the CMHT. It differed from the other Moving-On implementation sites in being far better resourced. The team received one week's Dialectical Behaviour Therapy (DBT) training, allowing the group to benefit from two sets of weekly small group supervision (Moving-On and DBT) in addition to weekly small group team meetings where the caseload was discussed. All three interviewees had external supervision arrangements in place, in addition to monthly management supervision. From an organisational point of view, this was the best resourced site in the research by a large margin.

While all three interviews were unique, reflecting differing professional socialisations and personalities, there was a consistent cognitive behavioural orientation across them. What seemed to be missing throughout was any reference to the relational and emotional aspects of the work. It was as though this has been edited out of the team philosophy entirely, where ‘Understanding’ (cognition) was consistently given a privileged position, followed by, ‘making different choices’ (behavioural). In this context, ‘being with’, ‘accompanying’ or ‘working through material in the therapeutic relationship’, were absent. My impression was of a somewhat cold, manualised, non-therapeutic theoretical structure, bolstering staff feeling as though they knew what they were doing.

An idea that formed in my mind throughout the course of the research was how Moving-On was a little like a reparatory offering in a process that was something like ‘marriage counselling’ between the two professions. An attempt to bring psychology in from its peripheral position, by taking up a role supporting care coordinators in the CMHTs to manage the floodgates of need.

Participant 5. Sue: nurse, care coordinator delivering Moving-On & DBT

Sue describes Moving-On in very positive terms, linking it to improvements in her confidence. She repeatedly refers to how it provided a ‘way into psychology’, where previously there was none:

> 39. “I helped roll it out and the teaching and stuff, which I do think’s had a huge impact on how we deliver a service to people and also how confident I feel myself”
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> -----------
>
> 73. “I would speak to psychology and they’d say, ‘they’re not ready yet because they’ve been seen in A&E’, or ‘they’re under crisis team’, or ‘they’ve had a hospital admission’. It was like, ‘but what do they need to do to be ready then, because they need this?”
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> 91. “The Moving-On Programme has enabled us to give people a starting point and has allowed us to make referrals into psychology”

She describes how the newly initiated supervision from psychology is central to her practice, where previously she felt unsafe and uncontained:

> 244. “I think supervision’s central”
>
> -----------

275. "I don't think I would want to practice without it either, having been in that position previously. . . I think it's really important, cos I FELT quite unsafe and not contained myself before. So how can I work with somebody if I feel like that?"

Sue seemed somewhat idealising of Moving-On and I felt she may be personally invested in its success in a way that impacted on her objectivity:

512. I "It almost sounds as though you feel like the services are there that need to be and nothing more needs to be put in place?
513. P I think, I think, I think, there needs to be more of us (laughter)
514. I It's a first cos I've never heard anyone say this before (laughter) so it's interesting
515. P (smiling throughout) I do I do think there needs to be more clinicians on the ground"

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612. I "Do you ever get people who are too complicated for the Moving-On Programme?
613. P No
614. I Too acute?
615. P No, we we've always done the Moving-On Programme"

Summary

Organisation-in-the-mind: The organisation is benevolent, perhaps even idealised now psychology supervision and a referral route into it are in place.
Organisational observation: This is a very well-resourced oasis, surrounded by a desert of poverty. The collaboration between psychology and the CMHT feels like marriage counselling, bonding two historically independent professions. Maybe psychology is trying hard to change its place within the organisation.
Participant status: This is hard to assess. She reports coping well, though also seems 'on message' when championing Moving-On. There is a lack of emotion throughout her interview. She doesn't talk about patients, but instead speaks of Moving-On, DBT and systemic issues involving psychology. My impression was she may not be 'at sea relationally', instead finding security, structure and a self-esteem boost from having been included in the roll-out of the manualised approach. She may prioritize cognition and behaviour, while avoiding emotions and deeper relating with patients.

Participant 6. Angharad: trainee psychiatrist, delivering Moving-On and DBT

Angharad's status as a trainee psychiatrist makes this a transitional role for her. She appeared privileged within the system and able to choose where she would work in the future:

138. "Long term, my plans don't include being a therapist"

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191. I "Do you know where you're going?
192. P Crisis
193. I okay
194. P I love crisis work"

She candidly describes her difficulty working with borderline patients and that she manages this by restricting contact with them:

102. "They can be enormously frustrating. Um most of my experiences are actually out of hours, over in the emergency department where they're making parasuicidal gestures"

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208. [Q-What helps?] "For me, the fact that I don't have to do very mu(laughing starts)ch of it is the brutal truth (laughing stops abruptly). I massively massively admire people who choose to go into the personality disordered oriented services because they are such challenging patients"

She feels confident to freely express her negative experiences delivering non-focal therapies. She explains she is a 'do-er' and doesn't believe in 'sitting around and chatting':

232. "I know that my strength doesn't lie with the long term therapies. When I was doing psychoanalytic therapy it was a good job the chairs were the kind of bucket chairs, with high sides, because … (makes sound of snoring). It's like you only get one patient and I just had no sympathy with my patient whatsoever and I'm very much .. a do-er.."

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242. "I'm very much a, 'so what are we gonna do to fix it?' rather than, 'let's all sit around and chat about it'"

Summary

Organisation-in-the-mind: She is the organisation's equal. She has power. She may feel the organisation needs her, meaning she can speak quite freely without fear of repercussion.

Organisational observation: It was evident when transcribing and reading her interview, that Angharad's privileged position in the organisation jarred somewhat with her less dominant position in the Moving-On pilot team.

Participant status: She openly acknowledges not being able to do therapy and finding patient contact difficult. She is very cognitively oriented, intellectualising throughout in a way that suggests she may cut off awareness of emotions in herself, meaning she is less able to attune to the emotions of her patients.

Participant 7: Robin: psychologist implementing Moving-On, CBT & DBT therapist

The final participant from this part of the organisation was Robin. She is an experienced psychologist, who found herself in "the right place at the right time, or the wrong place at the wrong time" when the Pathways were being constructed in the Trust. She became centrally involved with implementing Moving-On at the pilot site and is a CBT and DBT practitioner.

Robin is inherently intellectual and cognitive in her approach to therapy. For her, its 'all about understanding', something she has hope in. However, she is less confident about patient engagement:

> 2. "I feel quite hopeful that we could do something meaningful together, particularly helping them understand what's going on. But there's also concern about 'are they going to be able to engage?'"

> 44. "Being a psychologist is about trying to help people understand how they came to be where they are now. . . how come they've got the difficulties they have when other people maybe don't"

Robin explains Moving-On is about reaching more people through care coordinators than psychology otherwise could and that it isn't meant to be therapy:

68. “At any one time there might be 6, 7, 8 care coordinators in a team and they might have caseloads of 30, 40 people and a significant proportion of them are going to have this sort of diagnosis. So by doing something within the community teams we’re reaching a much wider range of people”

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223. “I would say that its therapeutic with a small ‘t’, in the same way that patting a dog might be, its therapeutic but it’s not therapy”

Robin recalls particular difficulty referring into the crisis team, though acknowledges if she were in their position, she may defend herself in a similar way:

424. “Yeah, so really having to lay it on. I think it’s as stressful trying to refer into the crisis team as it is sitting in a room with someone who’s suicidal”

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430. “I sometimes wonder what’s going on with people that work in crisis teams. . .if you just try and push away people with PD then maybe that’s easier emotionally for you to manage, cos you’re keeping them at a distance. If I was in the crisis team then maybe I’d be doing the same thing”

She feels staff need support to learn how to use supervision, but also that this is difficult to implement, as staff need their defences to survive:

773. “I do a lot of supervision with CMHT staff . . .as soon as you try to get them to start thinking about their own world or the impact on them you start hitting a blank wall”

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784. “They’re so busy and feel so overwhelmed, it’s too risky for them to start thinking about the emotional impact that someone’s having on you, because you know, you’ve then got to go back out into the fray. So you’ve got to put the defences back up again to survive”

She notes the medical model can be containing when resource constraints mean people have no time to think:

901. “If you’re overloaded and working with some really distressed and really risky people in your working week, the medical model is a really good way of containing the fall out... So I’d want some better support for staff in that way”

I ask Robin’s view about Simon’s (participant 1) caricature of the Moving-On Programme, “Moving-On, it’s in the title isn’t it?”. She offers a broadening perspective:

930. I One person said, ‘Moving-On, it’s in the title isn’t it?’ They noted change is what patients expected.

931. P Well in hindsight, it wasn’t the best name. We called it that because we wanted to show that we were trying to do something different and that there was hope that Moving-On was possible”

<u>Summary</u>

Organisation-in-the-mind: The organisation is inexpertly arranged. It is perhaps being educated in how it might respond better.

Organisational observation: Systemic shortages are acknowledged and psychology has usefully been brought into community teams. A behavioural and cognitive approach to PD patients is being advocated across the service, where ‘dependency’ is constructed negatively and patient ‘independence’ is prized.

Participant status: Intellectual understanding is prioritised over relational engagement and the resulting formulations keep a distance between therapist and patient. It may be that Robin as a therapist is never ‘at sea’ with patients, always maintaining a relational and intellectual, protective gap. She may cope by not ever really being connected.

4.1.4 Remote community mental health team (CMHT 2)

The fourth part of the organisation considered was a CMHT based further away from Trust Headquarters. Three interviews were conducted here, all from within one team. Interviews were conducted with a care coordinator with a nursing core profession, given the pseudonym Lena; another care coordinator, though with a social work core profession, given the pseudonym Grace, and the team manager, who also had a nursing core profession who I've given the pseudonym Richard.

Organisational observation

I had no prior knowledge of this part of the organisation or of any of its participants. One of the care coordinators responded to my scoping e-mail and then arranged for interviews with the other team members.

The multi-use building that houses this CMHT was located geographically far from Trust Headquarters. This separation from the main site was commented on by the manager in a positive way, in that it 'freed him from the politics felt more keenly at the centre'. While clearly under pressure, the individual team members seemed to function well; however, the manager was candid in being close to breaking point, having no supervision arrangements in place himself and receiving no organisational support. In this situation, he seemed to be containing his staff well enough, though at great expense to himself. I was aware of feeling quite concerned for him and wondered silently how much longer he could continue like this.

Participant 8. Lena: nurse, care coordinator delivering Moving-On

Lena presented herself as coping well, valuing the structure and limited time frames of Moving-On work:

> 5. "I enjoy working with that client group. I find it interesting, the more complex the more interesting it gets. I enjoy the boundaried way of working with them"
>
> -----------
>
> 173. "I think the 8 weeks helps me, the constant 8 weeks and knowing there's a beginning and there's an end"

She values supervision but states there isn't enough time to consider the personal impact of the work:

> 213. "We should definitely have more supervision. I remember being on a ward, you would have the end of every shift handover and that would be a time to be able to reflect and make sure you're not taking home all of that emotion that they can provoke"

She adopts a similar position to Robin, linking staff behavioural consistency with reduced patient 'dependency', contextualising this by citing limited staff resources:

> 143. "I think our borderline personality disorders tend to like the fact that they'll [out of hours triage service] sit and have a 50 minutes chat with them. The crisis team won't do that. We don't have time to do it. . . It feeds a dependency and an expectation of what we should all be doing . . .people with personality disorder need continuity, its gotta all come round the same way off everybody to reinforce and to give them security"

Organisation-in-the-mind: The Trust is impoverished, there isn't enough to go around, but it's better to have this than nothing.
Organisational observation: Supervision is valued but doesn't meet Lena's need to speak about the emotional impact of the work, there "isn't time".
Participant status: Lena says she is coping; however, this may be another example of someone who doesn't want to get too emotionally involved and so copes by 'not entering the sea' with patients.

Participant 9. Grace: care coordinator, social worker

Grace sees Moving-On as a tick box exercise that gets in the way of meeting patients' real needs:

> 44. "The idea of having a specific pathway is good, but a lot of stuff we're required to do is just ticking boxes and filling stuff in rather than actually following the story where it needs to go, 'we have to do this this week', 'this now'. It doesn't feel very client led"

She uses the Moving-On paperwork flexibly and views the relationship as the key tool she brings to the work:

> 170. "The main thing we bring to our jobs is ourselves, if we can't relate and model a healthy relationship to the person we're sitting with, then I don't think that's gonna be any good"

Grace tolerates the difficult feelings that come up with the work well, staying relationally close to people, while not becoming flooded:

> 549. "There's nothing I can do about her drinking bleach. I know that I have to accept it. I have to respect her because that may be all I can bring to that particular element, to say 'Okay, you are an adult that has a choice. You may well have been a child who didn't have choice, but I'm not gonna repeat that pattern'. . . I would certainly strongly discourage her . . . 'if you want to look at this, I'm here', and that offer is always open and repeated"

Summary

Organisation-in-the-mind: The organisation has the wrong priorities, well-intentioned but misguided. It prioritises the 'auditable surface' over patient needs.
Organisational observation: Robin feels empowered to work somewhat independently of organisational expectations, which she views as flowing from a 'tick-box' culture.
Participant status: Grace appears to be 'at sea relationally' and managing well.

Participant 10. Richard: CMHT 2 manager

Richard describes pressure from other parts of system being handed down to care coordinators. Like Simon (participant 1), he invokes the metaphor of war, describing the work as like a 'battle':

> 71. "there's a great expectation that we have all the answers and we don't. We're not trained and we're not (big exhale) not given the skills to be able to do that. It's not what our job is about, you know our skills aren't about housing and benefits."

> 75. "You're sort of battling against other things that are happening as well and then people not wanting to take ownership. . . We're saying we recommend you do: a., b. and c., and they don't want to do a., b. and c. (laugh)"

The idea of 'hope' is hard for him to contemplate, let alone discuss:

79. P “Hope?
80. I Yeah for them and their work
81. P (blows out) ERR for their recovery are you saying or for
82. I Whatever you think.
83. P So ERR how much hope do I hold Err. You get, I mean you go into it with an idea that you have a great deal of hope for them and, and, that, that
84. I Okay
85. P they will recover. Armm and I suppose that could and shouldn’t but could wane as things go on”

He feels the CMHT are unsupported by other professionals. Everyone refers into them but they cannot refer out, making brief work a necessity:

101. “The problem is the community teams are seen as the panacea, that all roads lead to us and that we’ll hold everything . . . You see band 7s band 8s working with these individuals and not wanting to know. It’s a bit like a hot potato and not wanting to take responsibility around the risk”

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103. “Because of pressures on waiting lists and caseloads we need to be moving them though, you know on. A flow through, and the longer we hold onto someone, it just backs everything else up.”

Given the systemic pressure acting on the CMHTs to ‘hold all the patients’, long term work becomes a threat to their survival. Referring to services like the Trust’s specialist therapeutic community (STC), becomes disincentivised as the patient would remain on the care coordinators caseload for too long:

119. “There is that frustration. If a care coordinator sends someone to the STC, that’s 3 years that person’s gotta stick sit on their caseload, because they have to be open to a care coordinator throughout the journey . . . I’m not saying that people don’t refer to the STC because of that, but…”

Vicarious trauma shows in staff sickness and there aren’t enough supportive spaces to work through these issues. While psychology is implicated, it isn’t targeted:

139. “You know people going off, not necessarily with stress, but they’re going off sick because its having an effect emotionally on them”

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215. [Q- what helps?] “The opportunity to have supervision, albeit not enough from psychology, but their hands are tied, it’s not their fault”

Richard seems close to breaking down completely himself. He describes being ‘on his knees’ and accessing local ‘therapy’ services:

253. “Personally, the problem comes when you try to get a balance between an open door policy and people almost queuing at the door to come in. Sometimes it’s only one problem, but there are occasions when there are 6, 7 of them wanting to come in. So you’ve got 6, 7 times the traumas. . . It can be quite challenging. Psychologically, you get on your knees a little”

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282. “Yeah it definitely gets home. It does go home, er, to the extent that I’ve just recently, I don’t know if it’s the right thing but anyway, I’ve self-referred to the local psychological therapies service. I’m doing a course on mindfulness”

A key issue seems to be a lack of time to consider the psychological impact of the work, both for staff and for him:

Staff:

340. “I think the pace is so fast that there is limited time to analyse that. I think the idea was that would happen in the supervision with psychology, but there is just an overwhelming number of individuals to be discussed and so it doesn’t get time to be discussed”

Him

366. [Q- Could you use the group to offload?] “Yeaaah there wouldn’t be the time there, I don’t think, yeah. I don’t quite know how that would work really because the staff are wanting and needing to discuss (cough) the, ah, their cases”

He would welcome closer ties with the STC, but feels they have a closed door policy. This is the main thing he would change to improve the service:

419. “To have a link between the STC and the community teams would be really beneficial, even if it’s just once in a blue moon they came up and talked to us about what we’re feeling and that its normal with this particular client group. . . It feels very much a closed door down at the STC and that you can’t get in there”

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545. “It’s all about having better communications with the STC. . . I think its multi layered, it isn’t just about more money and more staff. There is an element of that but I could have a team double the size and it would be no use if we’re not getting the communication right between the services”

Summary

Organisation-in-the-mind: Dumped on. CMHTs are ‘used’ by the organisation with little consideration from other parts of the service

Organisational observation: Trauma is getting soaked up by the manager. There is no time to reflect on the impact of the work and while the team may cope, he is close to burnout.

Participant status: He is ‘at sea relationally’ with patients through his containment of staff trauma; though is uncontained by other structures himself and therefore at risk of drowning.

4.1.5 Specialist therapeutic community (STC)

The final part of the organisation considered was the specialist therapeutic community. The STC is the intensive specialist personality disorder service. Patients attend the programme for three years, the first eight months are four days a week, 930-330 at the STC where they receive twice weekly psychodynamic therapy, once weekly group analysis and daily psychosocial activities underpinned by a Therapeutic Community structure (Haigh, 2013). The final two years and four months are spent in the Community Programme, where they receive therapy once a week, analytic group once a week and a psychosocial group every second week. This pattern of starting intensely and gradually reducing to a semi-supported structure, is intended to initially elicit ‘dependency’, before gradually returning agency to support more ‘independent’ functioning. The structure is modelled on the Cassell Hospital (NICE, 2009, p.180).

Organisational observation

The STC had a unique position within the Trust, being the only site where long term work with this patient group took place. This put it in potential conflict with other parts of the system, that were driven by a need to work in short time frames, given scarce resources and high caseloads, creating both a clash of resource allocation priorities and cultures. So, while crisis and the CMHTs worked to ‘suppress emotion’ and ‘support independence’; the STC’s brief was to support patients to ‘release emotions’, encouraging appropriate ‘dependency’, before gradually handing agency back.

Despite the strong emphasis on reflective practice in the STC, with numerous daily reflective spaces, there was a lack of capacity to think about wider system dynamics, leading the CMHTs and crisis teams to be stigmatised by the STC.

A recent innovation and olive branch from the STC to the other services were ‘Living Learning Days’, where staff from other parts of the Trust could come and experience what a day in the community was like. However, this positive move was quickly sabotaged by many subsequent cancelled events due to staff sickness and poor planning. This ‘falling through’ of the initiative may reflect a return to unconscious splitting and locating all the bad externally, while seeking to preserve all the good inside the team. In this sense, the STC may be similarly barricaded to the crisis team.

Participant 11. Jules: consultant medical psychotherapist

I worked with Jules at the STC for one and a half years. I also knew her a little in other professional capacities. Jules responded to my scoping e-mail, the only member of the STC team to do so.

Jules suggests there is a lot of stigma in services towards borderline patients, noting that with more damaged patients it can be hard to feel effective:

> 4. “So I guess I feel like it’s complicated (laughing). On the one hand, I’d say at a lower level, where people are not quite as severely disabled, there’s probably a level of stigma that I think is really unwarranted. . . I think it’s hard when you’re working directly with very severe, arm borderline personality disordered people to feel, arm Effective (bright)”

Supervision is essential to her, though comes mainly from the team. She notes how both the good and the bad patient projections get shared, protecting against either the ‘special relationship’, or ‘feeling completely hopeless’:

> 38. “The team functions to hold different aspects of the person, so I might be the one who’s getting all the good projections and I’m the good guy and somebody else has to be the bad guy . . . It stops you from feeling omnipotent, like ‘I’m the only one who can help this patient’, so that protects you from getting into a ‘special patient’ relationship. It also helps to protect against the other side, where you feel like you’re completely hopeless”

Like Richard (participant 10), Jules feels the organisation looks to her team to hold everyone, something she feels isn’t possible, unless the team were to grow:

> 195. “If you had a really difficult interaction, it may not have even been with a patient, it might have been with another part of the system, I think having other people that erm are there and understand you, ‘that’s rubbish isn’t it?’; ‘Yes’, you know just having that interaction its really helpful, it’s the relational thing”

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248. “My thought is rather than the STC trying to do everything itself, the idea of growing the capacity throughout the whole trust . . . The idea that we can hold and manage all the PD patients that the trust has got, it would take such a massive team. We could share our way of thinking. . . provide consultation but don’t necessarily hold the patients. I think that’s the most sustainable way.”

<u>Summary</u>

Organisation-in-the-mind: Difficult to tell. She takes a meta-organisational position and has the potential to be an organisational container.

Organisational observation: The STC is isolated, privileged in therapeutic timeframes and supervision arrangements, though paradoxically, also resource poor relative to the demands being made on it in by the rest of the service. It is internally reflective, yet defends itself externally through projection. Like the crisis team, it seems barricaded from external input. The STC constructs ‘dependence’ as being at the heart of good therapy, placing it at the opposite end of a binary with other parts of the service, who champion ‘independence’ and seek to remove ‘dependency’ reinforcing behaviours.

Participant status: Jules acknowledges the challenges of feeling effective, though also focusses on containing the team and its staff. It is difficult to gauge her underlying functioning, what she discloses and what she does not seems carefully calibrated.

4.2 Who is contained and who isn’t?

Operationalising ‘containment’, ‘coping’ and ‘not coping’

This section of analysis is concerned with identifying individual-level containment. Team and organisational-level containment will be considered in section 4.3.2 and 5.1.

Deciding from interview transcripts which staff members were contained involved a degree of subjective judgment. I present one understanding of staff containment, applying theory covered in the literature review to participant interviews.

In the preceding section (4.1), I started to describe how individual-level containment could be conceptualised under the heading: ‘participant status’. I started to differentiate between what ‘coping’ may be thought to consist in and how this differed from ‘containment’, using the metaphor of ‘being at sea with the patient’. I suggested one necessary condition for containment was a certain degree of emotional involvement with the patient and that in order to achieve this staff must themselves be contained. When this emotionally charged relationship is tolerated well enough by staff who are not generally overwhelmed, or acting to try and end these feelings, then they are receiving the patient’s unconscious communications, processing them and returning them in a containing manner (O’Hara, 2013; Bion 1962). Through this process they are providing the ‘holding environment’ (Winnicott, 1960) for the patient to internalise and where growth may take place. On this understanding, staff/therapist processing of unconscious patient material takes place whether or not staff are consciously aware of doing it. The patient’s projections are thereby ‘digested’ by staff and communicated back to the patient, having been modulated through these exchanges (Schore, 2012).

In the preceding section, staff who were suggested as not being ‘at sea’ were conceptualised as not being emotionally involved enough with patients for this to unconsciously register in the patient as ‘containment’. Staff who use this strategy to cope, may do so through overreliance on theoretical models or by just maintaining relational distance, though with the same result, staff are protected from identifying too much with the patient’s disturbing internal world. However, it is the degree to which such a defensive process forms a central part of someone’s normal coping strategy that is important rather than the binary presence or absence of it. For such emotional distancing is not pathological in itself and would be expected to form part of a spectrum of coping strategies that containing therapists’ and staff use too. Rather, it is the extent to which this is ‘over relied’ on by the therapist, or becomes their default position, preventing meaningful emotional contact in the therapeutic dyad being made that blocks the containing function of therapy.

Copers and non-copers

The above distinction suggests a hierarchy (see Figure 2, below): with ‘containment’ at the top; followed by ‘coping’, that has the potential to be more or less containing, depending on how it is achieved, and lastly ‘not coping’, where the therapist is unlikely to be containing of others, having lost the capacity to affectively modulate their own internal world.

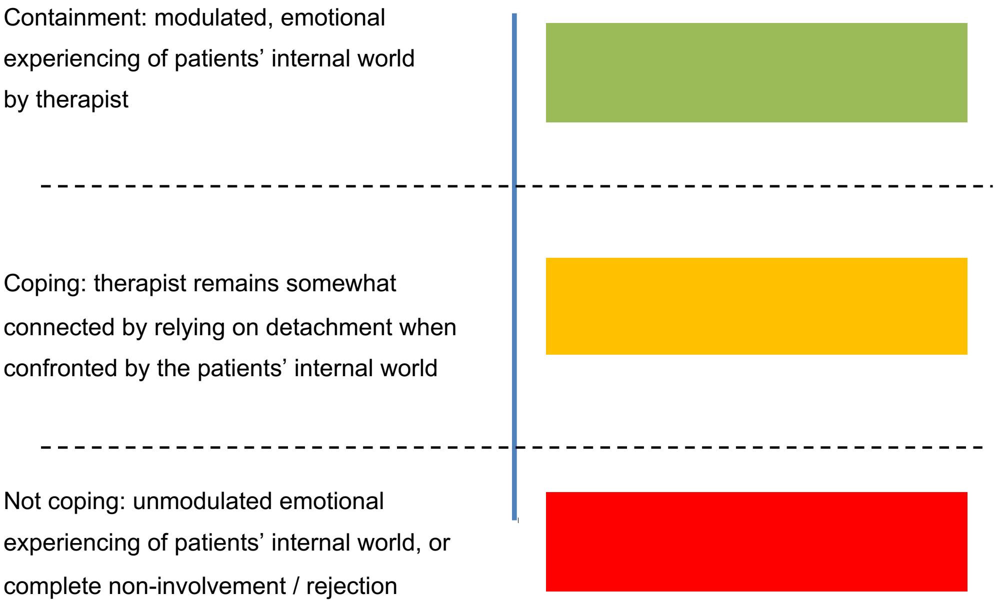

Figure 2 Hierarchy of containment

Non-copers

I suggest both Simon (participant.1) and Richard (participant.10) are not coping. Simon is explicit in letting us know this, telling us how ‘he struggles’, relying on the structure of the Moving-On paperwork. Without supervision, his lifeline would be lost.

Richard says he isn’t coping and appears close to burn-out. He describes taking the trauma home with him and accessing mental health services, seemingly because of the work.

Both Simon and Richard are ‘at sea’, in so far as they are allowing emotional connection to patients, albeit via staff in Richard’s case; however, neither is managing well. Instead they are overidentified with the patients’ projective demands (for further supporting data see Appendix 9.1).

Copers

I suggest the rest of the participants are coping to a greater or lesser extent, relying on personal or organisational structures to differing degrees to achieve this.

Who amongst the copers are containing?

Amongst the copers, some appear more able to provide containment, as evidenced by a capacity to stay more emotionally involved with their patients, while others seem less able to do this. Figure 3 (below) depicts the level of emotional identification with patients, from ‘too high’ and uncontaining on the left; to ‘too low’ and uncontaining on the right. The centre of this continuum is conceptualised as managed, or modulated emotional identification, which is understood here to be containing.

The kinds of staff response on the far left hand side of the continuum are more clearly identifiable, with participants overly showing and expressing signs that they are not coping. The type of behaviour on the far right hand side of the continuum is less easily visible, with emotional distancing and cutting off being harder to see. Participants on the far right hand side may therefore be ‘coping’ on a surface level, but doing so by not emotionally entering into relationships and therefore not offering therapeutic containment. However, by virtue of their better coping status, they may nonetheless be less likely to stigmatise borderline patients. While this may not be therapeutic, it does still mean that ‘coping’ may be clinically important to consider, with all the ‘far right’ participants being able to continue to hold mainly positive attitudes towards borderline patients.

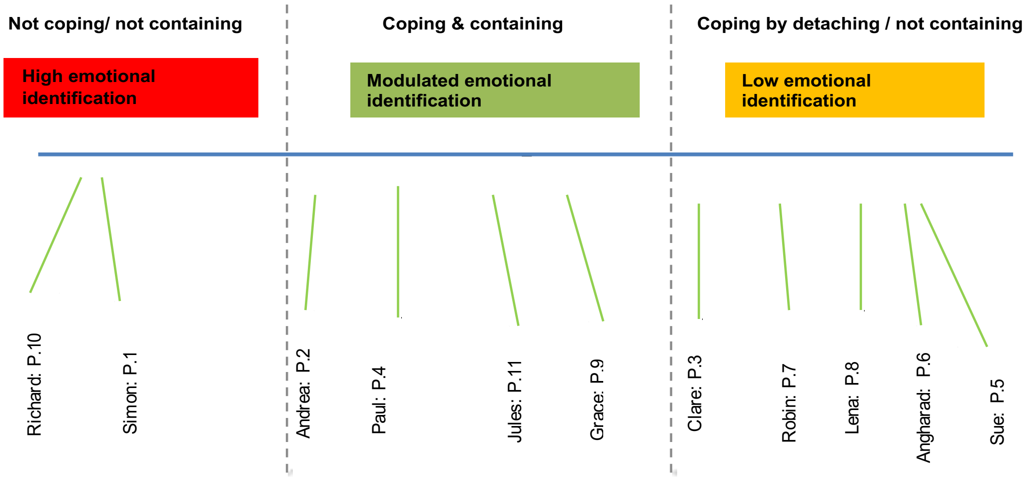

Fig.3 Continuum of containment

While capturing the distinction between contained and non-contained staff, this diagram is also just a heuristic device. In practice, it is unlikely staff would so neatly divide along an emotional identification continuum. Rather, less contained staff would be expected to fluctuate more between both sides.

Copers who are not containing

I suggest that Lena (participant 8- CMHT2 nurse care coordinator); Sue (participant 5- nurse care coordinator at Moving-On site) and Angharad (participant 6- trainee psychiatrist at Moving-On site) rely more on a distancing strategy, that potentially blocks therapeutic containment. Additionally, Robin (participant 7- psychologist at Moving-On site) and Claire (participant 3- nurse manager of crisis team) use this strategy, though to a lesser degree, but one that still appears uncontaining.

Lena's (participant 8) interview was initially hard to get a feel for. She is distancing, but also positive about patients. Lena described surviving the trauma of multiple suicides in her home community and left an intensive PD ward serving just one girl, that she spoke positively about and where she trained, to do 'brief' 8 session work in a distant community. There are some more emotionally angry moments towards the end of her interview, that together with her relief at the short term Moving-On structure, plus leaving the girl, all suggest a movement towards emotionally cutting off to do the clinical work (see also Appendix 9.2):

> Lena: 333. "Hanging is still very much a big thing in that area and there's not many people don't know people that haven't. So I suppose that casts a bit maybe of the way that I deal with things and people taking responsibility for managing their risk, because I know that you can't save everybody"

Angharad (participant 6) is aware she cannot do this emotional work with patients; important self-knowledge that allows her to distance herself from therapeutic work:

> Angharad: 208. [Q-What helps?] "For me, the fact that I don't have to do very mu(laughing starts)ch of it is the brutal truth (laughing stops). I massively

massively admire people who choose to go into the personality disordered oriented services because they are such challenging patients”

Sue (participant 5) seems less consciously aware of her emotional distancing. In the transcript this is evident through an absence of focus on patients generally, an idealisation of the Moving-On Programme, as well as in the counter-transference. I noticed uncharacteristic strong feelings of annoyance, of being controlled and not being given a straight story. Later, this was substantiated by what appeared to be misrepresentation by Sue. Together, these factors made me wonder if a process of projective identification into me was taking place and that this may be an unconscious strategy Sue used more widely. One possibility was that Sue may have been in services as a child, and her honed defences may still involve splitting off parts of her internal world that she cannot tolerate and locating them in others.

Sue: 151. “I’ve worked in mental health for over 25 years and I’ve been qualified as a nurse for 5 years so”
- Age on demographics is 32 yrs.

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202. “I think it’s partly down to experiences that they’ve had in their life and it’s also down to praps not having learnt those skills to manage those emotions. Coz we all have emotions you know, we all experience them, it’s just how we manage them at that moment in time”

Robin (participant 7) and Clare (participant 3) seem closer to being able to allow emotional experiencing with patients into them, though still rely too much on emotional distancing to be considered containing (see also Appendix 9.2):

Robin: 2. “I feel quite hopeful that we could do something meaningful together, particularly helping them understand what’s going on. But there’s also concern about ‘are they going to be able to engage?’”

Clare: 150. I “Does it impact you now do you think?
151. P Not so much and the reason I moved into Crisis work was, I think I I I’d had enough of Care Coordination”

Copers who are containing

I propose that both Paul (participant 4- systemic therapist in a psychology department) and Andrea (participant 2- nursing assistant in an inpatient mental health ward) are containing, modulating their emotional experiencing with a slight tendency towards higher emotional identifications. I also understand Jules (participant 11- consultant psychiatrist in STC) and Grace (participant 9- social worker care coordinator) as modulating their emotional experiencing in a containing way, though with an opposing tendency, being somewhat more inclined towards reduced emotional identifications (see also Appendix 9.3):

Paul: 326. "I firmly believe if you can sit with the emotional pain it will transform. I genuinely believe that it will transform but it's helping someone else do that (little laugh) when some of these things are buried so deep"

Andrea: 19. "Personally, I quite enjoy my work with people with that diagnosis and I like to think that I'm compassionate and non-judgmental without being a complete pushover either. I'm quite boundaried but I'm nice with it"

Jules and Grace are connecting in an emotionally modulating way, though through use of a little more distancing:

Jules: 57. "I think one of the mistakes can be to get too close, or become too attuned, because some patients respond either by needing to run a mile or to regress…You might think you're making progress but actually the patient might be feeling you're way too close."

Grace: 527. "I have to respect her decision, she's an adult with capacity. If that's what she decides she has to do to survive, then who am I to say that she shouldn't?"

4.3 How do contained staff achieve this?

The final section of analysis builds on the previous two, first exploring individual-level contributions to staff containment (Section 4.3.1, Themes 1-6), before turning to organisational-level contributions (Section 4.3.2, Theme 7):

Section 4.3.1 – this penultimate section constructs two themes (1 and 2) that identify and analyse a common relational process (A. Superordinate process) that contained staff relied upon when achieving therapeutic-level relationships with patients. This is contrasted with the relational processes achieved by copers and non-copers. Four more themes are then offered (3-6, B. Supportive elements) that identify individual-level factors that supported contained participants to achieve this higher-level, inter-relational process.

Section 4.3.2- the final section of analysis constructs one organisational-level theme (theme 7, C. Superordinate theme) that is explored in relation to factors that support or impede staff containment.

4.3.1 Overview of individual-level themes

Two themes reflect complementary sides of one superordinate process for achieving close, yet boundaried therapeutic relationships with borderline patients. The two themes overlap somewhat with one another, as does the evidence that supports them. However, they do appear to have somewhat distinct qualities that merit their separation.

All four contained participants made reference to these processes, while copers who were deemed uncontained, only partially made reference to them:

A. Superordinate process

Theme 1: Managing inter-psychic proximity - ‘empathic-adult’ position, &

Theme 2: Tolerating relational pain, attacks and not-knowing – ‘negative capability’ (Bion, 1984).

There were also a series of other themes relating to things that supported contained participants to achieve this superordinate process:

B. Supportive factors

Theme 3:	Personal therapy, or experience of therapeutic group process work
Theme 4:	Managed hope
Theme 5:	Control over exposure & informal spaces, &
Theme 6:	Transitional frameworks drawn from professional socialisations

A. Superordinate process

Theme 1: Managing inter-psychic proximity – the 'empathic-adult' position

Managing inter-psychic proximity involved striving to achieve a certain degree of empathic closeness in the relationship (see Figure 6, below), whilst not taking too much responsibility for the patient's decisions (see Figure 4, below), nor reverting to an overly punitive, detached position (see Figure 5, below). All contained participants demonstrated a capacity to manage inter-psychic proximity well, while uncontained staff struggled more with this.

Eric Berne's (1964) Transactional Analytic diagrams provide a useful schematic for thinking about these processes. He offers a simplified structure for describing how different parts within each of us: the adult; the child and the parent, are used to relate to one another. An added element is how conscious or unconscious these processes are, based on the degree of personal work we have done on ourselves. The diagrams are not intended to explain all of the conscious and unconscious dynamics taking place, this rapidly becomes too complex and hard to read. Instead, they are used as a device to pick out certain core elements of processes I suggest are vital to understanding staff-patient dynamics.

I have described the process outlined in Figure 4 as *'Merged' overinvolvement* and linked this to staff not coping in the longer term. In this dynamic, staff take too much responsibility for the patient's child-identified needs, due to a resonance with their own, unmet child-identified parts. Rather than containing the patient, staff unwittingly enact the patient's wish for total parental involvement.

'Merged' overinvolvement by staff

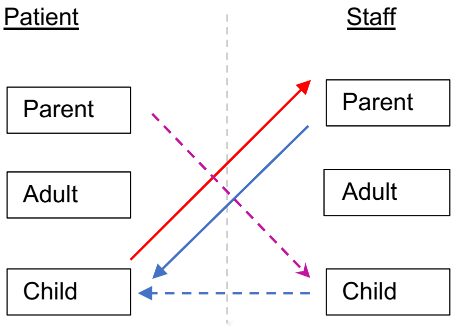

Fig. 4

Key:

—— or —— = Conscious level

- - - - or - - - - = Unconscious level

- - - - - - - - = Therapeutic action

I suggest the Figure 4 dynamic represents something the patient unconsciously longs for, that they never received developmentally and which the staff member is predisposed to more easily fall into without further support. For the purposes of the diagram above, both the patient's conscious and unconscious demands are signified by the one solid red arrow from patient's *child* to staff's *parent*. Staff agree to care from this parental position, allowing the patient to fall into a kind of regressive dependence seen in borderline patients placed inappropriately on mental health wards (Section 2.1, above). This is not a growth trajectory for the patient, even though on the face of it, it does contain some of the unconsciously longed for 'total holding' that was absent developmentally.

The staff member's agreement to meet the patient's needs in this scenario, is understood as having more to do with a resonance in the staff member's own unresolved, early child-identified needs, as represented by the blue hatched arrow from staff to patient's *child*. The purple hatched arrow highlights that this is not truly a therapeutic process for the patient, with a direction of therapeutic action that has as much to do with meeting the staff member's own transferential demands on the patient, as it does with any therapeutic effort towards the patient. This is therefore a kind of pseudo-therapeutic process for both of them, with staff unwittingly trying to meet their own triggered needs by fulfilling a rescuer role for the patient.

This is also an example of projective identification (Klein, [1946] 2018), from the patient to a receptively disposed staff member. In this situation, staff are unable to hold an *empathic-adult position* (Figure 6, below) in relation to the patient, as too many of their own early childlike needs have been triggered and the inter-psychic dynamic has become dominated by this process. Besides the growth denying quality of this process for the patient, a further negative consequence is its negative impact on staff. The overinvolved merged dynamic is exhausting for staff, as the patient's needs are endless when not appropriately contained. No amount of care within this dynamic will be healing. Staff are accepting too much responsibility for the child-like parts of the patient. The long term consequence of staff trying to fill this endless hole, will likely be burn out, followed by the need to cut off internally and/or detach externally from the relationship. This '*merged' overinvolved* process is thereby suggested to help explain the burn out literature, linked to staff feeling 'unable to help' and 'wanting to be better at curing' (Westwood & Baker, 2010; Woollaston & Hixenbaugh, 2008), as reviewed earlier (see Section 2.4).

The over-involved, merged dynamic was enacted by Simon (participant.2) and Richard (participant.6), who both felt overwhelmed, having accepted too much responsibility for the child-identified parts of their patients. That they were potentially taking part in a process of projective identification, would almost certainly not have occurred to them. This may have been partly because it was not part of any theoretical frameworks they were trained in and so was not a potential process they were watching out for. Nor was it part of their supervision arrangements, where this kind of reflective input might have helped them to disentangle such patient projections.

I have described the process in Figure 5 as *'Cut off' repetition,* and suggested it is another dysfunctional coping strategy used by staff when confronted with powerful patient projections that staff conform to a parental role for them. In this case, the patient's request is responded to at the social level, from adult to adult. It is suggested that underlying this process may be a repetition of rejection and a form of neglectful abuse. It is another form of projective identification, this time enacting the more cut off, original parental dynamic of the patient's early attachment figure. On a psychological level, the staff member's parent-identified parts are suggested to refuse to consider the patient's child-identified parts, instead requiring the patient to conform to an adult role ahead of their ability to do so. The childlike parts of the patient are excluded and staff respond purely to the patient's *adult*, albeit, from an unconscious position of repeating the transferential expectations of the patient:

'Cut off' repetition of rejection by staff

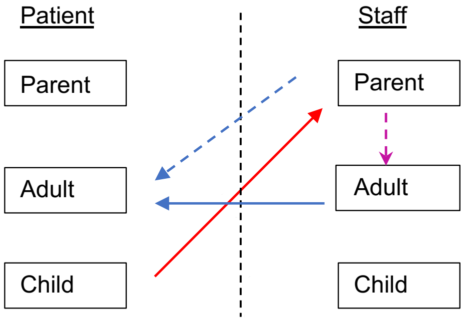

Fig. 5

While this is clearly not an objectively abusive process in the here-and-now context, the exclusion of the child-like parts of the patient through unconscious rejection of them by staff, repeats a lack of early care and nurture for the child-identified parts inside the patient. This time, the hatched purple line is located purely on the staff side, though still going towards staff, suggesting the intra-psychic process is more defensive, and again, more about meeting staff needs. It functions here to protect the staff member, by managing their exposure to the powerfully overwhelming needs of the patient.

This rejection of the more emotional, child-like parts of the patient is the dynamic I have suggested took place with Clare (P.3), Robin (P.7), Lena (P.8), Angharad (P.6) and Sue (P.5). It is perhaps most evident in Sue, Angharad and Lena, with Clare and Robin's responses seeming closer to allowing this more feeling side of the work to occur.

The third diagram (Figure 6), represents what contained staff do in response to patient demands that they enter into a parental role for them. Here, instead of identifying with the rescuer and merging with the child-identified parts of the patient, or identifying with the aggressor & rejecting their child-like parts, the therapist instead responds from an 'empathic adult' position. Here, staff can allow themselves to experience the powerful pull of the patient's *child*, whilst resisting the enactments of either retreating too much to a cut-off adult position, or merging too much with their child-like state. This ability to tolerate the affective demands of the patient, while retaining a thinking capacity to respond from a more grounded place, provides the patient with a potential growth space. This process also requires the second side of the superordinate process- 'negative capability', addressed as theme 2 below.

'Containment' of unconscious patient request by staff

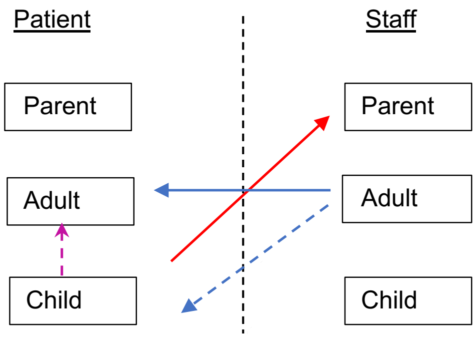

Fig.6

The potential for patient growth when staff adopt an empathic-adult position is indicated by the dashed purple arrow in Figure 6. As you can see, the arrow is now appropriately on the patient's side of the diagram, indicating an intra-psychic, transitional growth space within the patient, from a more child-like identification towards a more adult-identified position. Here staff maintain an adult to adult social level response, but are crucially able to simultaneously feel into the child identified parts on a psychological level, as indicated by the dashed blue arrow.

Examples

Robin provides an example from earlier in her career where she felt at risk of becoming overwhelmed and entering the merged, Figure 4 dynamic:

> Robin: 697. "She was 19 and so in my mind I was thinking 'what on earth do I do now?' And her being regularly suicidal for quite a few weeks and me feeling a bit out of my depth and like 'what am I supposed to do?' She's handing me all the responsibility to keep her safe and not engaging in it. I remember at that time going home and thinking 'what am I doing? I can't do this for another 30 years, this is crazy'"

Grace provides a good example of how hard tolerating the adult-empathic, Figure 6 process can be, when describing a patient of hers who drinks bleach. Here, Grace resists pressure to merge and take too much responsibility for the child-like part of the patient's destructive behaviour (Figure.4), whilst at the same time not defensively cutting off either (Figure.5), while under considerable pressure in the relationship:

> Grace: 549. "There's nothing I can do about her drinking bleach. I know that I have to accept it. I have to respect her because that may be all I can bring to that particular element, to say, 'Okay, you are an adult that has a choice. You may well have been a child who didn't have choice, but I'm not gonna repeat that pattern'"

On the inpatient ward Andrea, strategically deploys defences in the service of sustaining a balanced closeness in her therapeutic relationships. Here, Andrea consciously defends herself against taking too much responsibility, recognising this would lead to her getting 'sucked dry' and 'burn out'. She modulates her inner exposure to the patient using elements of a cutting off strategy, though this doesn't take over to become her core way of relating and is instead used in the service of being able to stay more connected over the long term:

Andrea: 111. “you feel somewhat helpless because there’s nothing you can do about something that happened 30 years ago 20 years ago. So those are the sort of things that stay with me, not whether I coulda done more cos at the end of the day they’re grown men and women. So I try not to take all that on board, otherwise you’d be sucked dry and burn out very quickly and I’ve done this job for 10 years”

Andrea, works hard cognitively to rationalise both her own and the patient’s behaviour, in an attempt to protect them both from Andrea’s own anger and frustration at her failed hopes for the patient’s recovery. This active process is part of holding Andrea’s own enactments in check, while also holding onto the patient’s child-like parts and trying to remain in an adult role with them, rather than allowing herself to be pulled to either of the uncontaining poles (see also Appendix 9.4):

Andrea: 99. “you just wouldn’t function if you were constantly getting annoyed and pissed off with them because they were not behaving in the way YOU wanted them to behave. And you know if they behaved in that manner then they wouldn’t need to be in hospital would they?”

Jules, describes how managing closeness in the relationship is a delicate area, with Paul echoing this. Both internally process and externally navigate the pull towards a ‘too close’, merged dynamic (Figure 4) and the push to a ‘too far’, cut off dynamic (Figure 5), in order to arrive at the more personally demanding, contained position (Figure 6). Paul articulates a further complicating factor, that the ‘too near vs too far’ staff processes, also reflect the poles of alternating states within the patient. The practitioner therefore needs to be able to survive the rough seas of being drawn in, then pushed away, in an ongoing cyclical process when working with borderline states (see also Appendix 9.4):

Paul: 210. “I think one of the difficulties in working with personality disorder is people’s internal worlds are often about wanting to belong, wanting to be part of something but also pushing away when they get it. So that makes it quite difficult to work with”

Theme 2: Tolerating relational pain, attacks & not-knowing - 'negative capability'

The other part of the superordinate process for achieving this kind of balanced connection with patients, is tolerating relational pain, relational attacks and not-knowing. This might involve not rejecting the patient who self-harmed when you left them; or not making increasingly emotional demands on a patient who self-harms, not to do so. This affect modulating capacity was evident through staff talking about working hard at tolerating feeling 'ineffective', managing their experiences of 'guilt', and remaining present in the work when they felt unsure, or without confidence.

The capacity to remain connected and not retaliate with anger, or relax the boundary when faced with escalating relational attacks, therefore represents the other side of this superordinate capacity. The examples for theme 1 therefore apply equally to theme 2; however, making a conceptual separation allows certain qualities to be thought about, even as the material doesn't lend itself to such easy division. Thus, the same three diagrams above (Figures 4, 5 & 6) also model the dynamics for Theme 2.

Examples

Grace and Andrea both offer compelling examples of this 'negative capability' (Bion, 1984; French & Simpson, 1999). Grace, when remaining emotionally connected to a patient drinking bleach (above) rather than retreating from them or becoming overinvolved. Andrea, when working hard to tolerate the feelings elicited in her by a patient who self-harms when she leaves them, rather than angrily blaming them, rejecting or stigmatising them.

> Andrea: 87. "I can spend two hours talking with somebody, go off to the toilet come back and they've been cutting at themselves and ligaturing. It's like 'Oh my g.word'. I just think for those two hours I was sat with them they weren't doing that, so in a way I've done a good job. . . I do feel that kinda guilt if you know what I mean, but I try not to let their actions make me feel guilty because all I can do is my best, try to be kind & compassionate and move people forward"

Jules describes how organisational arrangements support her to not become overwhelmed with all the negative projections. These are understood as organisationally containing structures, so are dealt with in the *Overview of organisational-level themes,* in Section 4.3.2 (below).

Both Jules and Paul highlight how feeling ineffective is a difficult and necessary part of the work:

Jules: 4. "I think it's hard when you're working directly with very severe arm borderline personality disordered people to feel arm Effective (bright)"

Paul: 81. "with others it just feels as though the damage is too great and I, it can feel like I'm getting nowhere"

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285. "I'm not saying I don't feel effective working with personality disorders, its just much slower"

Staying with uncertainty, together with not-knowing if what they were doing was working, was something all contained participants actively struggled with:

Paul: 318. "I'm working with a client at the moment, her inner world is ah is incredibly sad I mean it really really is hard sitting with the pain she experiences. . . it's something about how to, how to help"

Andrea: 285. "Sometimes I don't know what I'm doing, so you just feel ill-equipped to deal with this 'blurrrb' that comes out when they've told you something that's very intimate. I often think 'am I saying and doing the right thing?', you know. I don't (dysfluence/emotion) I've never done any formal kinda training in that area"

Jules: 6. "I feel that's probably the biggest impact, it's hard to feel like you've really been able to make a difference. Or, you know you make some gains or some changes and then it's very easy for them to fall apart and not hold onto them"

Grace: 536 I "That'll end her life at some point presumably?
537 P Yes, she's inhaling fumes, she has a nasty cough, its gonna burn her insides.
538. I So how do you do that?
539. P Its the serenity prayer isn't it. It's having the strength to change what you can, accept what you can't and being able to tell the difference between the two"

Some participants seemed insufficiently able to tolerate patients' pain, instead retreating to cognitive defences, but nonetheless did have some ability to balance responsibility in the relationship (Figure 5). They were judged to be coping but not contained. Thus, while Sue (participant.5), Robin (participant.7) and Lena (participant. 8) all located responsibility back into the patient in the relationship and therefore didn't become overwhelmed (Figure 4), they did so by rejecting the patient's challenging negative emotions and cut off too much (Figure 5), which reduced their ability to manage inter-psychic proximity and achieve the *adult-empathic position* (Theme 1) with patients.

Robin: 68. "I remember a supervisor when I was doing some CBT training saying to me that if you're feeling frustrated by somebody, or erm you know getting really irritated by the way that they are in the sessions, then it probably means you haven't got the formulation right yet. So by having a good formulation that really helps with empathy"

Lena: 335. "So I suppose that casts a little bit maybe of the way I deal with things and people taking responsibility for managing their risk, because I know that you can't save everybody"

Sue: 202. "I think it's partly down to experiences that they've had in their life. And it's also down to praps not having learnt those skills"

B. Supportive elements

Theme 3: Personal therapy or experience of therapeutic process work

Three of the contained participants made reference to personal therapy, or therapeutic group learning. They reflected on this as being central to their developing a capacity to differentiate their own material from patient material, as well as to have faith that change was possible, these were: Andrea (inpatient health care assistant), Paul (systemic psychotherapist in psychology) & Grace (care coordinator in CMHT 2). The fourth 'contained' participant Jules (consultant medical psychotherapist in the specialist therapeutic community-STC) didn't make reference to therapy in her interview, though was happy for me to share that she undertook individual, three-times-a-week psychoanalytic psychotherapy for a number of years as part of her professional training, this being in addition to the STC group reflective processes, themselves another kind of group process training (see also Appendix 9.5):

> Paul: 110. "I think what sustains me as well if I'm honest, is I have had to go through therapy myself and had to look at quite a few of my early experiences and ah that gives me hope as well"

> Grace: 166. "in the PD Service it was quite a therapeutic way of working, thinking about what's essentially in the room, you know 'how are you reacting?', 'are you feeling maternal?' It was a very close team and we felt able to challenge each other and say, 'well I think you're being a bit such and such'. It was an immense learning curve and somehow once you've got that awareness you can't unlearn it"

Of the other 'non-contained' participants, none made reference to undertaking personal therapeutic work; although Lena (care coordinator in CMHT 2) found her experience of 'check outs' at the end of the day in the secure hospital where she previously worked valuable for 'leaving the patients behind' (see Appendix 9.5). She also cited 'life experience as worth its weight in gold', referring to the many suicides in her home community. However, together with relying on a short time frame for the work with patients (8 sessions), this was offered as evidence that Lena relied too much on a cut off process to cope in the work, at the expense of 'close enough' emotional proximity to achieve therapeutic-level containment.

Robin (psychologist at Moving-On pilot site) was also judged to be coping but not containing. She specifically made reference to not undertaking therapy, stating that if she ever needed it she would access it, but never had (see also Appendix 9.5):

> Robin: 657. "God, this might sound really arrogant or patronising, but one of the things I was brought up with was this idea of, 'if it ain't broke don't fix it'. So, I don't think I would ever resist accessing therapy if I felt I needed it for something specific but I haven't done it as part of training or professional development"

Richard (manager of CMHT 2), a non-coping participant, had recently self-referred to the local IAPT service in an overwhelmed state close to burnout. However, he didn't report any prior experience of therapy (see Appendix 9.5):

Theme 4: Managed hope

A process of maintaining a more realistic, managed form of hope supported the work of contained participants. This appeared to be an active, conscious process (see also Appendix 9.6):

> Andrea: 33. "I have hope that people will make a certain type of recovery"

> Paul: 152. "I guess I'm talking about hope on quite a small, micro level rather than the macro level"

Holding this kind of hope is challenging and seems to involve a decision to sit with the disturbing actions of the patient, not becoming over-identified and over-involved (see also Appendix 9.6):

> Grace: 106. "I've seen people make outstanding changes in their lives, and that's inspiring... I mean sometimes people are very obviously not ready, but that becomes clear pretty early on"

> Jules: 6. "I feel that's probably the biggest impact. It's hard to feel like you've really been able to make a difference, or you know, you make some gains or some changes and then it's very easy for them to fall apart and then not hold onto them... I feel sometimes it's easy to lose hope"

This process of maintaining a managed form of hope was also used by copers who were less contained:

Robin: 270. “I think I’m always hopeful about the work we could do with them. I think where I feel less hopeful is about the system around that”

Clare: 62. “I’m hopeful. You’ve always got to maintain hope for them, because if the professionals aren’t hopeful, how can the service user take that on board”

Theme 5: Control over exposure & informal spaces

Being able to manage exposure to patients and having informal spaces for respite was important for contained participants. While this is an individual level process, it is also an organisational one, in that the organisation may support or hinder access to it (see Section 4.3.2). See Appendix 9.7 and:

Paul: 274. “I need a lot of reflective space for myself, so I make a point of getting that and sometimes I walk out of the building to take space”

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308. “I’d say there’s not enough reflective, physical space in this building, there isn’t any”

Informal peer supervision could function as respite, where processing and detoxification of unconscious identifications could take place:

Andrea: 253. “Cos that can be equally important, just to have sort of peer supervision with each other in the staff room. You know like have a cup of tea together and just go: “god, you know she’s driving me bloody nuts!” and sometimes that’s enough”

Jules: 193. “Also to just informally vent you know, just go into the coffee room and go ‘ahhh I’m having a really bad day’. I think having other people that are there and understand you know, ‘that’s rubbish isn’t it?’ ‘Yes!’ Just having that interaction its really helpful, it’s the relational thing.”

Understanding when to seek out more formal supervision seemed to come from self-awareness:

Grace: 252. "I think there are always going to be some people that stick with you and you find yourself thinking about a bit later in the day. Sometimes, that's just a bit about you processing what's going on. Sometimes it indicates that maybe I need to take this back and talk to somebody about it, whether that be in supervision, or just with one of ma colleagues"

For those participants who were coping but weren't contained, an inability to manage physical exposure to patients may explain part of the reason they needed to rely on relational defences (see also Appendix 9.7):

Robin 785. "I think a part is that they're so busy and feel so overwhelmed that it's too risky for them to start thinking about the emotional impact that someone's having on you, because you know you've then got to go back out into the fray"

Lena: 173. "But I think the 8 weeks helps me, the constant 8 weeks and knowing there's a beginning and there's an end"

Likewise, for those who were flooded and not coping, often this coincided with having high numbers of patients on their caseloads and little power to address this:

Richard: 103. "Because of pressures on waiting lists and caseloads we need to be moving them though, you know on, a flow through, and the longer we hold onto someone… it just backs everything else up"

Clare: 149. "I moved into crisis work because I'd had enough of care coordination. . . the amount of people that you have on your caseload where you're firefighting and risk managing constantly"

Theme 6: Transitional frameworks drawn from professional socialisations

A final theme was how people conceptualised their work and this linked to having a theoretical framework. It seemed that while having a theoretical framework was neither necessary nor sufficient for achieving containment, it did scaffold coping and was often involved in containment, when not overly relied upon. This is another example of an individual level containment process that could equally be supported or hindered at an organisational level, the Moving-On intervention being an example of the former (see Section 4.3.2).

Participants in this research used a variety of frameworks, though some had none. Such frameworks may be considered transitional objects (Bell,1990 [Main, 1966]; Winnicott, 1953) providing a supportive means to bridge the divide between the person's inner world and their outer roles and relationships. This may include giving the practitioner confidence that what they were doing was somehow 'right'. However, containment as defined in this research goes beyond this. Someone who relies too much on any theoretical framework runs the risk of not experiencing and tolerating the emotional demands of the patient in the relationship: they can't achieve therapeutic-level relationships through the superordinate process that requires both the 'adult empathic position' (Theme 1) and 'negative capability' (Theme 2). In this less contained scenario, the transitional object is clung to too tightly, in order to protect the practitioner; whereas, the contained practitioner is able to hold onto these transitional conceptual objects more lightly, as supportive props rather than life rafts.

Richard seemed aware of this way in which the framework could be held more or less tightly, when he noticed how the proscribed Moving-On framework was relied upon less rigidly by more experienced practitioners, who could work more therapeutically:

> Richard: 315. "You've got some clinicians who are more confident in working outside of the box appropriately and erm doing more therapy as opposed to just assessing. So it depends on the staff member and it depends on the client, you know how receptive they are."

For Jules, prior work in 'autism' seems a safe base to return to. Used this way, the medical model of diagnosis was perhaps functioning as a transitional object, allowing her to feel more confident while moving into a new leadership role in an established PD service:

> Jules: 304. I think we've got a lot of patients who've got an undiagnosed autism or autism traits. So I would really like to be picking those up and screening for them more easily. I would put that in to the whole of Anonymous Partnership Trust.

Robin, Paul and Grace all viewed the medical model (as applied to mental health) as an unhelpful, reductive framework (see also Appendix 9.8):

> Grace: 388. "As a social worker you're trained to question the medical model. That's a key part of social work training"

> Paul: 86. "I think it's just a label anyway, personality disorder. . . I think it's a convenient label often used in psychiatry, to label people who they are unable to build a relationship with or who seem to be presenting with difficult behaviours"

> Robin: 901. "If you're overloaded and working with some really distressed and risky people in your working week, the medical model is a way of containing the fall out... So I'd want some better [theoretical] input for staff so they don't have to do that"

Clare observed how nurses are 'task oriented', making therapeutic work with borderline patients a particular challenge:

> Clare: 447. "Cos nurses are task orientated in our thinking . . . the idea of long term models of working would require a whole shift of attitude"

Sue (care coordinator at Moving-On pilot site) and Robin both rely on cognitive and behaviourally derived frameworks (see also appendix 9.8):

> Robin: 697. "I remember at that time going home and thinking 'what am I doing? I can't do this for another 30 years, this is crazy'. . . that was around the time DBT training was coming on line. . . that changed everything"

> Sue: 145. "I think in the early days when I didn't have that structure I probably went home worrying far more about 'oh crikey are they going to be okay?' and 'what will happen if something happens?'. Where now, I don't have that anxiety and that's partly from having structure, as well as experience and working my way up"

Paul relies more on a systemic framework:

> Paul: 92. "I sometimes wonder if our whole culture's got a bit of a personality disorder"

108. “So um, so what sustains me is perhaps a bigger picture, of seeing people within a context.”

Grace identifies with a more personal centred, or psychodynamic tradition, emphasising ‘being with’ the person as a transitional framework (see also Appendix 9.8):

Grace: 170. “The main thing we bring to our jobs is ourselves. If we can’t relate and model a healthy relationship to the person we’re sitting with, then I don’t think that’s gonna be any good”

Angharad (trainee psychiatrist at Moving-On pilot site) found any kind of solution-focussed structure helped her:

Angharad: 242. “I’m very much, ‘so what are we gonna do to fix it?’ rather than, ‘let’s all sit around and chat about it’”

Andrea doesn’t feel she has a framework, though still manages to offer containment well:

Andrea: 133. “Weeeel, I don’t know if we have a particular fraaamework as such. They talk about these different frameworks you know, like SAFTI but I’m not sure if there’s anything firm. I mean obviously we all have a lot of supervision and we have ‘x’ [particularly admired supervising therapy nurse]”

The above copers contrast with Simon (care coordinator at CMHT 1) and Richard, who felt they had no theoretical framework and instead relied on the manualised Moving-On Programme paperwork (see Appendix 9.8):

Simon: 115. [Do you have a framework?] **“**No, no no no no no. No, I there’s a lot of er different thinking in the paperwork. That works for some people and doesn’t work for other people, but the structured paperwork gives me a focus really.”

Richard: 71. “there’s a great expectation that we have the answers and we don’t. We’re not trained and we’re not, (big exhale) given the skills to be able to do that”

4.3.2 Overview of organisational-level themes

The degree of organisational-level containment of staff teams was judged from: 1. the relative health of the various parts of the organisation, as inferred from organisational observations and organisation-in-the-mind inferences (Section 4.1 & Figure 1); 2. participants' containment status (Section 4.2 & 4.3.1), and 3. participants' face value, verbal descriptions of what supported them in their work.

C. Superordinate organisational theme: Team exposure

One overarching theme (theme 7) of 'team exposure', was constructed from patterns within and across the data. Team exposure expresses the degree of 'relational exposure' the organisation implicitly requires staff to have with patients, relative to the structures and practices it provides that offset this.

The organisation could intervene to reduce team exposure and mitigate against staff becoming overwhelmed, or using 'cut off' defences by: 1. reducing caseload sizes; 2. offering training in theoretical systems (transitional frameworks), and 3. giving staff control over exposure to the work, through informal spaces and reflective spaces. However, there were equally things the organisation could not control or intervene with, such as its budget, social level crises like the Covid-19 outbreak, or psychologically damaging cultures: a 'culture of narcissism' (Lasch, 1979); a 'turning away from our inner worlds' (Bollas, 2018), or widespread internalisation of capitalist values (James, 2007). Such external pressures on the organisation are a form of exposure that leaders and managers must process and contain if they are not to pass this down to their teams.

In this research, the level of team exposure did relate to a team's ability to remain generally open, reflective and connected to their patients' inner worlds; or, to need to be more defended, cut off and to stigmatise them.

Crisis team

While all parts of the organisation were exposed, some were more so than others. The crisis team, for example, was highly exposed, though coping 'well' independently of any obvious leadership contribution. This was in contrast to the CMHTs, who were also highly exposed but seemed to be coping less well:

> Clare: 539. “I know that colleagues over at Trust Headquarters in the community teams have got major difficulties with recruitment. So I’m lucky in that respect and the nurses I have on my team [the crisis team] are all really experienced.

As outlined in the organisational map (Figure 1) the crisis team was suggested to have organised a group-level defensive strategy that preserved internal relationships, though at some cost to other teams and patients. It ‘barricaded’ itself both against other parts of the service and against borderline patients specifically, who were likely stigmatised and excluded. This barricading may have helped bond staff together in their work through a common internal strategy. It is an example of a social defence against anxiety (Menzies-Lyth, 1960), achieved through a culture of distancing staff from physical and emotional contact with borderline patients (Evans, 2014; Francis, 2013). It is a kind of traumatic organisation at a local level (Bloom, 2011), with the team relying on a dissociative strategy and then reflecting disturbance back into referring teams, thereby amplifying affective disturbance to other parts of the service.

Robin summarised what I heard staff across the organisation say on numerous occasions:

> Robin: 424. “I think it’s as stressful trying to refer into the crisis team as it is sitting in a room with someone who’s suicidal”

The crisis team hadn’t always functioned this way. It used to provide early intervention and outreach work. It was designed by one of the committed staff members who still worked there, having returned on a bank work contract after retirement. He explained how successive resource cuts over the past 10 years meant his initially progressive plan had been eroded, leaving the regressive, reactive service that now remained. The crisis team now only managed medication and access to the wards, no longer offering psychosocial, early intervention work. He seemed a little sad about this, but also resigned and somewhat cut off.

Robin, the psychologist from the pilot site, described how crisis team members couldn’t use supervision to reflect on the personal impact of their client work (see also Appendix 9.9):

> Robin: 773. “I do a lot of supervision with CMHT staff . . .as soon as you try to get them to start thinking about their own world or the impact on them you start hitting a blank wall”

She generously notes how if she worked in the crisis team, then she may need to adopt this approach too, acknowledging the over-exposure of their systemic position:

> Robin: 430. “if you just try and push people with PD away then maybe that’s easier emotionally for you to manage, cos you’re keeping them at a distance. If I was in the crisis team then maybe I’d be doing the same thing”

I suggest this barricading strategy is used by staff because they are flooded by external demands. Their group survival is based on not knowing about what is happening to themselves internally, meaning they cannot risk entering the disturbing inner worlds of their patients. To survive, crisis team workers rely on a social system of defence that keeps this dangerous knowledge away. The organisational offer of containment through supervision is therefore understandably rejected by the majority of staff in this context (see also Appendix 9.9), as it would only threaten the defensive functioning of this system.

Team exposure isn’t just modulated by social defences of distancing and dissociation in the crisis team, but also by moving responsibility from the individual-level to the group-level. A therapeutic version of this process commonly takes place in group reflective spaces, such as those offered at the Trust’s specialist therapeutic community (STC). The crisis team’s shared caseload functions in a similar way, and was something Clare, the manager, described as drawing her to the team:

> Clare: 163. “So for me to have time off with stress, I knew I had to do something different and I’d worked in crisis work before and the thought of a shared caseload was quite attractive to me”

No single worker having to hold ultimate responsibility for any given patient limits the burden on staff, reducing individual-level exposure by spreading it across the team. However, unlike in reflective group processes, where anxiety and disturbance is processed to deepen therapeutic relationships; in the crisis team, spreading responsibility functioned more as another social defence, further distancing staff from patients by breaking up nurse-patient relationships, as in the original Menzies-Lyth (1960) study.

The urgent nature of crisis work means patients can't wait for an allocated worker, they need a response now, making a shared caseload necessary. However, a collateral gain of this setup for strained workers was having less relational exposure. This made it more likely that PD patients would become dehumanised, a process paving the way for intolerance, prejudice and exclusion.

That this dehumanising process was 'not because the crisis team staff were bad people', as Clare notes (Section 4.1.1, line 6,), was also my experience. As Robin suggests (Section 4.2, line 430), this may be the response anyone working in such a wrung out system would have needed to take.

Community mental health teams

The organisation implicitly requires the CMHTs to tolerate similarly high levels of exposure. However, while the crisis team could effectively barricade themselves, the CMHT could not. Nor could they benefit from the buffering effects of a shared caseload, or of excluding difficult PD patients, as crisis did.

As Richard (P.10) observed, 'there's an expectation the community teams will hold everything' (Section 4.1.4, line 103). Pressure on waiting lists meant he must ensure the team 'move people through', a process that prohibited longer term relationships with patients. In effect, this is another example of a culture that defends against forming therapeutic-level relationships based on the 'adult-empathic process' (Theme 1) and 'negative capability' (Theme 2).

The Moving-On Programme may be seen as a positive attempt by the organisation to intervene to contain team exposure, though provision of a transitional framework, the collateral gain of which was to simultaneously replicate a defensive culture that limited the potential for therapeutic-level relating. To return to the climbing analogy, it attempts to move staff from the more exposed position where they are hanging in space on the exposed buttress, to the safer feeling slab, where they are surrounded by the more solid faces of a manualised approach. While still requiring staff to make the same moves and hold the same caseload, it makes the route ‘feel’ easier, providing a map and also imposing limits on staff proximity to individual patients (8 sessions/ 8 hours). Here, limiting contact may flow somewhat from economic considerations; equally, it may be argued to also mitigate team exposure, functioning more to end the suffering of staff, than that of patients (Hinshelwood, 2014).

Simon, the first CMHT worker interviewed, observed how, ‘for him the paperwork was an aid’ and something he clung to (Section 4.3.1, Theme 6, line 115 and 128). While for those who were more experienced at working in exposed conditions, the framework could be used more flexibly:

> Grace: 74. “I think I’m asking it in a much simpler and a much looser way”

Grace, a CMHT 2 worker, observed that while such frameworks may be held lightly to support positive practice, the danger was they might become tick box exercises for burnt out staff:

> Grace: 342. “it invites clinicians to proceed in a certain way and if somebody was not in a great place themselves, struggling or you know under pressure just from too much work, it could very easily become a tick boxy thing.”

For CMHT staff who lacked the underlying capacity to work in more overly exposed conditions, the Moving-On framework may have offered enough of an organisational container to lift them up to ‘coping’ status. Thus, Sue, Angharad and Lena all appeared to function ‘well enough’ by relying on the framework, though were not personally well resourced enough to manage the added exposure of more emotionally involved, therapeutic-level work. This is equivalent to being able to climb easier routes, but not harder ones: the transitional framework allowed predictable moves on the less difficult terrain, but not moving to the next level of exposure, emotionally modulated, higher level, contained practice.

Nevertheless, this meant the Moving-On framework may have supported a degree of ‘empathy’, in that it protected some staff from reverting to the more dangerous defences of intolerance, prejudice and exclusion, as the crisis team had. The Moving-On intervention may therefore be both an important, and a limited contribution to better patient care. It may offer improved relationships and control over the negative extremes, but also imports and perpetuates a defensive culture of keeping a relational distance, both intra-psychically and inter-psychically.

The factor that differentiated the two CMHT’s from the Pilot Site, was the latter’s vastly greater degree of supervisory input (see Section 4.1.3), whereas, both CMHT’s reported not having enough time to reflect in supervision (see Appendix 9.9: Richard and Lena). One possibility is that the weekly supervision introduced by Moving-On, was itself a highly significant intervention. Supervision might then be seen as the transitional framework within which the processing of patient projections could more easily take place:

> Grace: 226. “I think the quality of supervision from psychologists is very good. The fact that’s its Moving-On programme focussed isn’t a barrier, it’s still helpful.”

Specialist therapeutic community (STC)

The initial analysis summarised in the organisational map, suggested the specialist therapeutic community (STC) was similarly barricaded as the crisis team. This initially surprised me, as I hadn’t experienced the two environments as similar. However, on deeper reflection a similar kind of defensive rejection of ‘other’ parts of the service was taking place, even as the STC contained its staff more, through better leadership.

While working in the STC, I was struck by the way otherwise empathic, intelligent and theoretically minded people lacked compassion for staff in other parts of the service, who were treated more as adversaries than colleagues.

The apparent privilege of the STC: being able to do long term work with a small group of patients (max 8); enjoying frequent group and 1:1 supervision; having multiple daily reflective spaces; and a high staff to patient ratio (effectively 1:1), was at odds with the relatively poorer resourcing and support in other parts of the system, except perhaps the Moving-On site. One possibility was that a kind of animosity, perhaps akin to sibling rivalry existed towards the STC from other parts of the service, with envy and hostility to the STC resulting in unconscious attacks back outwards by the STC, to its sibling teams. Another possibility is that the STC may have become identified with its patients' splitting potential, locating everything 'bad' externally, in order to preserve the 'good' within its own staff and patients.

Richard, the remote CMHT manager, often made reference to wanting closer ties with the STC, feeling they were 'out on a limb', impoverishing both the community teams and the STC (see also Appendix 9.9, Richard: 465):

> Richard: 419. "To have a link between the STC and the community teams would be really beneficial, even if it's just once a blue moon they came up and talked to us about what we're feeling and that its normal with this particular client group… It feels very much a closed door down at the STC and that you can't get in there"

While Jules, the STC consultant, appeared to lead well, coping personally and containing the team, this didn't extend to helping the team integrate split-off organisational dynamics, thereby leaving the STC in a similar position to the crisis team, in an organisationally marooned position.

As with other parts of the Trust, Jules may only have had so many resources to give and may have prioritised her immediate team and patients over its relationships to other parts of the service. It may be that caseloads were ultimately too high to spread herself across the other leadership functions. If this were the case, it would again implicate funding shortages imposed from outside the organisation as ultimate causes. In this scenario, organisational exposure was being passed down through the consultants to the STC team, before being defensively transferred out to other parts of the service. This protected the team's inner functioning and its patients, but did so by spreading toxicity to sibling teams in the organisation. It can therefore be seen as partially mirroring the crisis team dynamic.

An additional possibility is that the unique history of the STC and the personalities that drove it, were implicated in its 'isolated and isolating' position in relation to the rest of the Trust. These dynamics may have meant that complex projections of toxicity could not be reflected on internally and so were diverted safely outwards to the rest of the service, rather than having to be reflected on by a team that was fundamentally stuck at an impasse in relation to part of its leadership team.

Unlike the crisis team, but similarly to the Moving-On site, the STC had a culture of supervision and reflective practice. For the STC, this was underpinned by a psychodynamic model that gave more weight to relational dynamics, than to cognitive and behavioural features. This over-arching theoretical model may have helped to support the team to partially retain an internal culture of reflection, even as it was not sufficient to contain all of the negative projections, some of which had to be diverted outwards.

Inpatient ward

The inpatient team seemed to be coping well. Andrea was judged to provide therapeutic-level containment (Section 4.2 and 4.3.1); nonetheless, she represented the team as split:

> Andrea: 173. "As a team we're quite split and divided, so some of us are quite compassionate and work quite well with this diagnosis and other people really struggle with it and find it difficult to Cope with having to deal with the behaviours"

I suggested that contrary to Andrea's view, the organisation may in fact be containing its staff well from over-exposure here. The reflective group spaces that Andrea sometimes wanted to attend and sometimes didn’t (Section 4.1.1, line 221 & line 246), may in fact have been part of a containing group process. Thus, by not giving in to Andrea’s not wanting to attend, the leader may be ensuring a group process takes place. In this situation Andrea may want to hold onto all the good projections, leaving others to hold all the bad ones. However, these splits are not allowed to continue through Andrea’s non-attendance; instead, she feels pressure to attend and a process of integration takes place, where she has to take her share of the negative projections.

Andrea describing her peers as ‘struggling with borderline patients’, may therefore not necessarily be a cause for concern. What matters is the extent to which these difficult feelings are dealt with, internally or within a group process, rather than being enacted & manifested externally. Hence, to be able to ‘hate’ one’s patients may also be important (Winnicott, 1949), but this is quite different from expressing this to them. Returning to the two figures proposed earlier (Section 4.3.1, Figure 4 & Figure 5), the question may be to what extent staff remain caught in the Figure 4 or 5 dynamic, rather than sometimes being able to move into the more therapeutic, Figure 6 superordinate mode.

It is inevitable and perhaps even oddly ‘helpful’ that staff will sometimes enact the Figure 4 & 5 processes, because the goal is not ‘perfect’ attunement. This might even be somewhat unhelpful, not allowing a growth space for rupture and repair to take place within. Rather, the goal is to achieve ‘good enough’ care for patients, by providing a ‘holding environment’ (Winnicott, 1965) in which independent growth becomes possible and staff can gradually ‘fail’ the patient in increments the patient is strong enough to tolerate.

The inpatient context also differed from the other research sites, in that the significant external pressure on beds was contained by managers, with ward staff being largely protected from this organisational exposure. The pressure on ward staff, was that they could not easily leave, making the ability to control their proximity to patients and to one another through informal spaces, a vital counterbalance to what might otherwise become an authoritarian requirement to attend all reflective groups. From Andrea’s report, the organisation manages this balancing act quite well, giving staff sufficient freedom to take space when they need it, whilst also sometimes requiring them to attend to integrate challenging material.

Significantly, Andrea's organisational context did not provide any explicit theoretical framework to support her in the work (Section 4.3.1, Theme 6, line 133.). She described prioritising 'being with' patients and 'consciously struggling' to maintain these relationships (Section 4.3.1, Theme 2, line.87), but seemed to rely on supervision (Section 5.1.1, participant 2, line 221), informal spaces (Section 4.3.1, Theme 5, line 253 & line.233) and holding herself to account against her own moral philosophy (Section 4.2, Copers who are containing, line 123) to achieve this.

Psychology

Paul didn't rely on the organisations offer of supervision, feeling the relationship 'wasn't as open as it could be' (Section 4.1.2, line 278). However, he described needing a lot of reflective space (ibid, line 274) and noted this wasn't possible within the psychology building (Section 4.3.1, Theme 5, line 308), so he would leave. His leaving the building was interesting to notice, as it paralleled the way other staff members in psychology would also systematically leave the building every 2 hours to move their cars.

A structural lack of reflective space within psychology is surely a curious thing to ponder. Does it reflect a lack of resources? Does it reveal what psychology views as important? Or, could it be that like the crisis team, on some level psychology is unable to reflect on the work it was doing, for fear that unconsciously constructed social defences might crumble and it wouldn't cope anymore? As with the ultimate causes of the STC's outwardly defensive posture, specific answers to these questions are beyond the scope of this work.

A tendency for psychology to not mitigate staff exposure through the provision of reflective spaces, didn't seem to impact Paul. He had established enough internal structures to not need to rely on the organisation for containment. He could independently tackle the more challenging and exposed climbing routes, needing less external support to do this.

It may be that psychology workers didn’t experience the same pressure of high caseloads that other parts of the service did. Paul didn’t mention caseload pressure in our interview, nor was it a feature I observed when briefly working there as a trainee. As with the STC, it may be the potential exists for this to cause envy and frustration towards psychology from other parts of the service who are more overwhelmed. This could also help contextualise its peripheral location and the observations about differential parking arrangements and staff regularly leaving the building.

A further organisational factor mitigating exposure for both Paul and Jules, was their greater levels of seniority within the organisation, together with the freedom and autonomy this afforded them. While holding more responsibility, they also enjoyed more autonomy and so could choose to ‘leave the building’, something more junior nurses and support workers might be questioned on. This might equally be framed in terms of their having a greater freedom to control their proximity to the work (Section 4.3.1, Theme 5), with seniority in the organisation providing unequal individual-level benefits.

What all four contained participants appeared to possess was a kind of earned confidence that what they were doing was somehow right, even if they didn’t feel sure it fitted any specific framework. Through experience, they may have become more personally contained practitioners and more able to independently process patient material. So for Paul and Jules, who didn’t report needing to rely on supervision to remain contained, they may have internalised previous supervisors and therapists sufficiently to no longer need to rely so much on external organisational structures. This might then place a greater premium on having external space to process internal responses to patient material, something the organisation could support or hinder through its choices.

Psychology’s union with the CMHTs through the Moving-On Programme appeared to be a generally positive, structural intervention. Bringing psychology supervision into the community teams was an organisationally containing act, that modulated, exposure passed down from the organisation to its teams. It supported the less extreme defences, by reducing rejection and stigmatisation of PD patients, but didn't support the reflective space or the time frames needed for therapeutic-level relating (Theme 1 & 2) (see also Appendix 9.9: Lena, 213).

> Lena 177. "Supervision every week is beneficial. However, I don't think we've always got enough time to fit everybody into that supervision discussion… our supervision group meets once a week for two hours but that two hours is basically all our clients"

> Richard: 340. "I think the pace is so fast that there is limited time to analyse that [impact on staff]. I think the idea was that would happen in the supervision with psychology, but there is just an overwhelming number of individuals to be discussed and so it doesn't get time to be discussed"

By delivering the Moving-On Programme, psychology stepped into a more organisationally containing role, though with limits on its ability to be effective. This union between the CMHTs and psychology was considered 'marriage counselling' in the organisational map, reflecting the idea that psychology had been somewhat 'out in the cold', whether because it placed itself there, or had been placed there. The greater integration between psychology and other disciplines was viewed as therapeutic at a services level, helping teams from different professions to come together to manage the extreme exposure passed down to them by the organisation from broader society, and allowing psychology to have a more meaningful and connected role in the organisation's work. However, Moving-On also reinforced a dissociation of workers from their own internal worlds', allowing insufficient space for this to be considered in supervision, thereby making it more difficult for them to enter the internal worlds' of their patients and achieve the therapeutic-level relationships described by Themes 1 & 2.

CHAPTER 5

CONCLUSIONS

5.1 Main findings & conclusions

The overall aim of this research was to better understand ‘what contains the containers?’, where the containers are NHS staff working with patients attracting a borderline personality disorder diagnosis. The question was framed using psychodynamic theory (Bion, 1962; Ogden, 2004; Winnicott, 1960) and relied on a binocular, psychosocial analysis (Richards, 2019).

The research questions sought to divide a complex, inter-relating array of causal processes into distinct conceptual areas, so they could more easily be thought about. The usefulness, impact and transferability (Elliott et al, 1999; Yardley, 2000) of this work may be judged by the extent to which it helps to elaborate what supports or hinders practitioners to offer contained practice, to achieve coping status and to identify ways to reduce stigma and discrimination towards borderline patients.

> ***Objective 1***
> *The first objective was to gain an impression of the relative health, or traumatic organisation of the various teams within the organisation, including how they related to one another and to the organisation.*

Findings: The health and functioning of the various teams studied in this research, as outlined in the organisational map, (figure 1.), is framed within a non-mainstream paradigm, importing the therapeutically driven construct of ‘containment’ together with other elements of psychodynamic thinking. This complements mainstream constructions of what counts as ‘evidence’, ‘success’ in clinical work, and ‘healthy organisational functioning’, by drawing on an elaborated array of sense making criteria and constructs.

Accordingly, this research found that all Community Mental Health Teams (CMHTs) were traumatically organised, although some coped better than others. Workers were flooded by demand that was greater than the resources provided to them to deliver services. Managers described an overriding pressure to ‘hold everything’ and felt they were a ‘dustbin’ for the rest of the Trust. Traumatic organisation was evident through: staff needing to remain relationally cut-off with patients; an implicit construction of ‘dependence’ as pathological; by relying on non-therapeutic frameworks and times frames for the work, and in not wanting to make referrals for longer term therapy services available in other parts of the Trust due to pressure to ‘move people through’. Burn out was described as being high amongst this group and recruitment was difficult. Many referred to the work as ‘like a battle’, and not feeling ‘armed’ or ‘supported’ by the Trust, who they felt only paid lip service to delivering a good enough service for these patients.

The Moving-On pilot site CMHT was resource rich and coped better than the other roll out CMHTs. It was nonetheless still seen as traumatically organised in terms of the defences its staff used to cope. So while they somewhat coped internally, and so could seemingly manage the flow of patients adequately, this was at the expense of offering a therapeutic-level service. Instead, the concept of ‘dependence’ was constructed negatively and short times frames and inter-relationally distanced work prevailed. It would perhaps be revealing to ask patients how they experienced these services. My suspicion is they would echo what the crisis team manager said, “I don’t want to knock the Moving-On programme, but 8 weeks? It’s taken people a lifetime to come to where they are now. I don’t think anything can be undone is 8 weeks”.

The Moving-On pilot site was suggested to be the vehicle for taking a deeper, therapeutic process forwards between the CMHTs and the profession of psychology. This process was likened to couples therapy and understood as brought about by the introduction of a Trust wide, 8 week intervention for working with borderline patients, supported by weekly psychology supervision of CMHTs.

The crisis team and specialist therapeutic community (STC) were both presented as relying on social defences in the form of ‘barricading’, where this made referring-in, or open peer relations between teams more difficult. These are considered examples of traumatic organisation, albeit impacting on borderline patients more directly in terms of stigma and exclusion with the crisis team; whereas for the STC this trauma manifested outwardly, to staff in other teams. That these two parts of the Trust differ so much: the STC championing appropriately longer therapeutic timeframes (3 years) and some degree of 'dependence'; the crisis team always seeking to remove people from the case load and championing 'independence', is perhaps revealing. Despite the considerable resources available to the STC and the good work they did with patients, its position within the Trust remained a barricaded one in relation to the rest of the organisation, trauma being passed down from under-funding at a societal level through the consultant, via the STC staff and into other teams.

One part of the Trust that was viewed as functioning in a healthier way from within this research paradigm, was the inpatient mental health ward. Here, the staff-team were 'sealed in' (see Figure 1) and team dynamics were largely managed through access to expert group supervision balanced with informal spaces. The inpatient ward being sealed in, meant that external pressures couldn't impact on staff in the same way that they did for the CMHTs, crisis and the STC. Perhaps in their hermetic isolation, pressure on the inpatient ward walls was successfully contained by management. Equally, the nature of the inpatient service may have contributed to this, with 'dependence' being inevitable. Atomistic justifications of 'independence' could not therefore function as a social defence against the tide of unmet need as elsewhere in the rest of the traumatically organised system.

Conclusions: Most of the Trust functioned in traumatically organised ways that were not therapeutic for the patients approaching them for help. That patients will experience further iatrogenic traumatisation within such systems is to be expected when the timeframes for work are set at 8 weeks and delivered by untrained professionals. Patients approaching such a system for help are met with staff who defend themselves from coming into contact with their patients' affects, denying them a deeper sense of being related to. These staff defensively rely on the organisation's top-down constructions of 'independence', implemented via cognitive and behavioural interventions that function in quasi-abusive ways. They do this by repeating patients' developmental expectations of not being relatable to in more human, interpersonally attuned ways and denying them a therapeutic space to learn that appropriate adult ‘dependence’ can become a safe, adult achievement to internalise.

This detached staff offer to borderline patients reinforces their deeply held belief that they are ‘too damaged’ and that there is ‘no possibility, or hope of change’. This will likely be experienced as ‘yet another failed treatment’ and therefore bears on the suicide findings outlined by Paris (2004, p.240-241) “borderline patients …usually kill themselves … later, if they fail to recover, or when a series of treatments have been unsuccessful”.

That this is not because the staff working in such services are bad people is self-evident. Rather, these are examples of good people whose thinking and behaviour have been deformed by a system that is under resourced to deliver adequate care. It instead draws on reductionistic, anti-relational constructs to deliver too little care, defensively protecting itself from external scrutiny. If you are one of the lucky few who manages to gain a place at the STC or other similarly therapeutic services, then you will receive a different, therapeutically meaningful experience. However, for staff interacting with the STC, and for STC staff relating outwards to other teams, the organisational norm is likely to remain the ‘survival of the numbest’, for all but a resilient few.

> ***Objective 2***
> *The second objective was to establish which staff were ‘contained’ through a more detailed analysis of their responses. I applied psychodynamic theory relating to the concept of containment to answers that participants gave to questions about their experiences of working with borderline patients. This allowed me to develop a key conceptual framework and to venture a tentative placing of respondents along this continuum, from more to less contained, with examples to support this.*

Findings: The research identified eight staff who were ‘coping’ and two who were ‘not coping’. Of the copers, four were suggested to be reaching a higher, more therapeutic level of interpersonal relations, that was considered ‘containing’.

I assumed that copers were less likely to stigmatise and discriminate than non-copers, but that ‘copers who were not containing’ were ultimately taking part in a non-therapeutic process, even though patients would likely expect to receive a therapeutic service.

Conclusions: This distinction between ‘contained copers’ and ‘non-contained copers’ was introduced through the psychodynamic ontology and application of the construct of ‘containment’ from therapy work. As such, the paradigm imports certain assumptions, for example, that the NHS intends to offer genuinely therapeutic services. However, this paradigm may be at odds with service provision in the NHS.

The psychologist at the Moving-On pilot site suggested their work supporting CMHTs through the Moving-On programme was: *“...therapeutic with a small ‘t’, in the same way that patting a dog might be, its therapeutic but it’s not therapy”.* The intervention was contextualised as being designed to offer overwhelmed CMHT staff a framework to help them cope better and to deliver a more consistent service. My research found it may have succeeded in supporting staff to ‘cope’, but that it did not help them to offer ‘therapeutic containment’. Such a process may be partially containing of staff and reduce stigma and discrimination by allowing staff to manage better. How such a service is experienced by patients would require further research.

It seems reasonable to assume that distressed borderline patients presenting to services might well expect, or at least hope, to receive a genuinely therapeutic service. However, having spent most of their lives in varying degrees of emotional and relational turmoil, their being offered an 8 session, manualised intervention by a detached, largely untrained worker seems unlikely to be experienced in a positive way. As noted in the previous conclusion section, the experience would likely reaffirm their developmental conclusions, that they are people who cannot be related to, and that there is no hope of this changing. Again, I link this to Paris’ (2004, 2019) suicide statistics for this group, ‘they kill themselves only later, after a series of treatments have been ineffective’.

The psychodynamic paradigm is invested in relational work and real change, whereas the Trust's intervention may more clearly be seen as aimed at reducing staff contact with this patient group in order to manage the overwhelming numbers of patients presenting to services. I conclude that such an approach may increase the risk of eventual suicide for this group by reinforcing and also repeating their experience of relational isolation and hopelessness that things can change.

This research paradigm may therefore be unwelcome from the Trust's perspective, as it reframes the Moving-On intervention as a framework that encourages a pseudo-abusive relational dynamic and is expected to increase the risk to the group. That this is not what the Trust would want is not in question; rather, it is the unconscious, protective social defence of a system that does not have the resources to deliver a higher, truly therapeutic, standard of care.

> ***Objective 3***
> *The third objective was to analyse the data of participants who were identified as more contained, in order to investigate how they achieved this.*
>
> *The goals at this stage were twofold. Initially, an analysis that explored the macro-zoom, close-up level, looking for common thematic patterns & strategies used intra-psychically and/or inter-relationally by contained staff. The second analysis then applied a wide-angle lens, incorporating the findings of Objective 1 & 2, to look for higher-level explanations of staff containment flowing from team or organisational-levels.*

Findings: This final part of the research initially focussed on the group of people who were identified as contained. It looked in detail at the process of contained practice in these staff, offering an integration of research with practice to provide a schematic for how staff achieved contained practice. This superordinate process (themes 1 & 2) consisted of allowing a degree relational proximity to take place where patient projections were taken in, whilst also holding boundaries, not taking too much responsibility for the patient and tolerating the experience of suffering empathic pain without trying to end it. People who were able to do this tended to have been in personal therapy themselves, or to have had experience of therapeutic group supervisory processes (theme 3). They held a cognitive orientation to patient improvement that didn’t set hopes too high, but still held some hope (theme 4), and they drew on various theoretical frameworks as well as none, but did so in a ‘light way’ that didn’t undermine the superordinate process (theme 6). They needed informal spaces to process the work and to disconnect themselves from patients (theme 5). Some found supervision more important than others, possibility as a function of experience, more experienced practitioners no longer needing so much external supervisory input.

Organisational factors that related to contained practice were less evident. Contained practitioners tended to be so in spite of organisational arrangements. More senior staff required less organisational permission to take informal space and relied less on supervision. They also did not require training in frameworks, tending to already have these in place. Less experienced contained practitioners may have relied more on organisational containment in the form of reflective practice spaces and permission to take informal space.

The organisational theme of ‘exposure’ was explored across service settings. The Moving-On intervention was considered as offering a degree of organisational containment to CMHT staff, possibly helping them to ‘cope’ but not helping them to become ‘contained copers’, something that was precluded in the way Moving-On supervision was delivered by preventing any reflection on the patients’ affective material within the staff. An implicit injunction on reflection was mirrored across the most traumatised parts of the service, such that when organisational exposure was too great, reflective spaces were found to function as a threat to social defences, and so were resisted. Crisis team workers were the best examples of this, a majority not having supervision arrangements in place, although as mentioned, Moving-On supervision also didn’t allow staff time to reflect on their work.

Conclusions: The superordinate process encapsulated by themes 1 & 2, provides a primer for more genuinely therapeutic practice. For people attracting a borderline diagnosis, this is suggested to hold the possibility of being met in a relationship that affords a transitional space for growth and real change to take place. The supportive elements of themes 3-6 may be regarded as valuable things to strive for when training and selecting candidates for this work.

The superordinate process and its supportive elements may reflect a kind of awareness the Trust cannot face knowing. Within this paradigm, ‘coping that is not containing’, while potentially protecting patients from stigma and discrimination, may be experienced as a repetition of the kind of cut of, pseudo-abusive care that they received developmentally. If this registers as another example of ‘failed care’ then such intervention may directly contribute to an increased risk of suicide in the longer term.

The Moving-On programme may therefore be viewed as laying the tracks for a pseudo-abusive relational process to take place, where the appropriate degree of inter-relational proximity (theme 1) and negative capability (theme 2) are missing. That some staff are able to offer contained practice within such a framework, seemed to be in spite of this framework, rather than because of it. The framework itself does offers supervision on a weekly basis, but precludes reflection on the impact of the work, or on how emotions in the staff may be relevant to understanding patients’ experiences. The ‘relational’ is thereby excluded, replaced by a “tick box” approach. It is suggested that this arrangement of priorities mirrors those is society more broadly, where the inner world of human experience is treated as largely irrelevant. For people attracting a borderline diagnosis, a predicament that is fundamentally about failed developmental-relational experiences, this non-relational paradigm is therefore exactly the wrong kind of intervention.

If the organisation were to support staff to use supervision in a more self-reflective manner, then this would require an overall reduction in team/ organisational exposure. This could be supported by access to informal spaces and transitional frameworks; however, this will never fundamentally be enough. This is because not only do staff defences against relational proximity need to be brought into awareness, but crucially, there also needs to be change in the material circumstances that led to the need for the defence. Therefore, while a flood gates of need remains, reflection on the impossibility of the task and consequent collateral damage to patients cannot admit of the defence coming down. As Robin noted: *“They’re so busy and feel so overwhelmed, it’s too risky for them to start thinking about the emotional impact that someone’s having on you, because you know, you’ve then got to go back out into the fray. So you’ve got to put the defences back up again to survive”.*

Mental health nurses not being able to connect to their own and their patients’ inner worlds, instead relying on cut-off strategies, together with systemic interventions that cement this way of relating, means that most borderline patients will be met with the opposite of what they really need. This may not only be untherapeutic, but ultimately increase their risk of eventual suicide, through reinforcing the implicit feeling that no one will ever connect to them in a relationally attuned, safe way.

The STC appears to be the one part of the Trust that is functioning in a more healthy, therapeutic way. Nevertheless, even this Gold Standard service cannot adequately contain the toxicity passed down to it by the broader social system, which is directed outwards into other teams and staff members, throughout the Trust. At least in this rare part of the service, such toxicity does not spill outwards towards patients too.

The inpatient ward appeared to also function well, containing its staff and patients. This place of ultimate safety was suggested to be working well and may represent a different end of the therapeutic journey, where ‘dependence’ is for once allowed in a system that otherwise disavows it.

Overall conclusions

Bernard: *"Sir Humphry and Sir Ian will be laying down some 'informal guidelines'.*

Hacker: *How do you mean informal guidelines?*

Bernard: *Well guidelines are perfectly proper Minister; everybody has guidelines for their work.*

Hacker: *I thought these planning inspectors were supported to be impartial.*

Bernard: *(laughter) Oh really Minister. So they are. Railway trains are impartial too, but if you lay down the lines for them that's the way they go."*

Yes Minister: A Middle Class Rip Off (Jay & Lynn,1982)

Mental health diagnosis is predicated on an atheoretical framework that places peoples' observable behaviour into neat 'boxes', paying no attention to the social, developmental, psychological or economic circumstances that brought about these experiences, that is, the aetiology of their suffering. Such aetiology is well specified in many theoretical frameworks and much empirical literature; however, because there remains no consensus on which literature to follow, then this invalid and unreliable system continues to guide 'treatment' and certain mainstream research forms.

Receiving a borderline diagnosis is fraught with danger. It puts people into a category that is viewed as 'difficult' and 'untreatable', where a limited to non-existent range of treatment services is available; unless, that is, one has the money to pay for private therapy. As one of my participants noted of the borderline diagnosis, *"it's a convenient label often used in psychiatry, to label people who they are unable to build a relationship with, or who seem to be presenting with difficult behaviour"*. It places the person 'over there', rather than seeing them as the product of their relational and developmental history; on a shared continuum, a process much more likely to elicit empathy.

Relying on diagnosis to place people into these atheoretical boxes, with matched, rigid, manualised interventions like Moving-On to complement them, echoes what takes place in much of the rest of the mental health system, or should I say 'mental health market'. It is a perversion of care (Rizq, 2012, 2014) at both human and organisational levels, where emotional suffering is turned away from, replaced by a ‘tick box’ target culture (Dalal, 2018). Moving-On contains much of this hypocrisy at is core. It was created from the control condition of Bateman & Fonagy’s (2009) research into mentalisation based therapy (MBT) called Structured Clinical Management (SCM). This control condition initially reduced harm faster than MBT but over a slightly longer period, MBT was found to be superior in all other ways. Rather than investing in care coordinators receiving training in the meaningful and effective therapeutic intervention, they were instead trained in the ‘managed care’ control condition, an 8 week extended assessment delivered by nurses with two days training.

Thus, the tracks were laid down in such a way that very few people presenting to mental health services would receive the care that might stand a chance of really making them better (Marks, 2018; Rizq, 2012, 2014; Scott, 2018; Shedler, 2010, 2018). It starts with the framing of their difficulties in a meaningless way, proceeds to stigmatise and discriminate against them through a system that is ill equipped to offer meaningful therapy, and ends by failing staff and patients alike, leading to increased hopelessness and risk for both. This needn’t be the case.

Services like the STC reflect the best of what NHS service can offer, but even these services are operating in traumatically organised ways, in that they cannot work together with other sibling parts of the trust. Instead, insufficient understanding of what is required, &/or the funding to provide this, means that longer term therapy services like the STC are experienced as ‘the enemy’ of short term work aimed at ‘moving people on’ through the rest of the system, as with the CMHTs and crisis team.

The inpatient wards are a place of safety and final resort when everything else has failed. They offer physical containment when all other services have drawn a blank, but are not in the business of therapy. Nor is there a system to support people to receive therapy once they leave there, unless they are one of the lucky few who gain a place in a longer term service, like the STC.

Psychology input into such a system, through an intervention like Moving-On, may be seen as laying down the tracks for a system that will fundamentally fail this patient group, most of the time. Indeed, a definition of psychology in such a context might be, “making inadequate NHS services marginally less inadequate”. To what extent are we therefore complicit when providing this kind of psychological input to such a system, is surely something we must all reflect on.

5.2 Limitations of research

The findings of this research flow from its critical realist ontology, meaning realist claims to nomothetic ‘truths’ are not being made. Rather, the research attempts to look in detail at how real work happens within complex systems, in an attempt to achieve findings that are closer and more relevant to everyday clinical practice (Yardley, 2000, p.215). Moving from more rigidly controlled, quantitative methods, to these more nuanced qualitative approaches, may mean the research has less traction for mainstream decision makers, where commissioning tends to favour more restrictive, quantitative methodologies and constructions of ‘evidence’ (Rost & McPherson, 2019; Shedler & Gnaulati, 2020; Shedler, 2018). Nevertheless, I hope this analysis is sufficiently transparent and grounded in examples to allow readers to form judgments about the credibility, coherence and rigour of these findings (Elliott et al., 1999; Yardley, 2000) for themselves.

A limitation of this research may relate to the range of participants who opted into it, as this was based on my scoping email that asked ‘What helps people survive in the work?’. While some of the participants were clearly not coping, the selection is likely biased towards those who felt they were coping, rather than those who weren’t. Extensions of this methodology might seek out more of the participants who did not feel they were coping so well and look more closely at their individual, team and organisational circumstances to better understand risk factors for poor containment and coping.

A further limitation may be the breadth of research ambition. The limited word count may not have allowed as much space as the reader would like to be able to fully explore any given topic. Further research might take up any one of the questions dealt with and explore it in more detail. A more distilled focus on any single element might deepen its meaning. An associated limitation was having insufficient time to peer data check in groups to further support credibility checks. This might have generated new and richer ways of looking at the material, as well as enabling more of my unseen contributions to become evident.

A final area of contention might be the charge that my ontology reflects my owned perspective, applied psychodynamics, to too great a degree. One could argue my framing of clinicians as ‘not contained’ because they excluded too much of the relational material, flows from my construction of containment, vis-à-vis a psychodynamic lens; whereas, a cognitive behavioural practitioner might view my construction of a ‘non contained’ exemplar as paradigmatic of good practice. Nevertheless, I would argue the ontology of applied psychodynamics is essential, and that the set of constructs it imports into analysis, allows for deeper and more clinically effective work to become possible (Bateman & Fonagy, 2019; Fonagy et al., 2004; Shedler & Gnaulati, 2020; Shedler, 2010, 2018, Western, 1998).

5.3 Implications for counselling psychology and broader practical applications

The British Psychological Society’s Division of Counselling Psychology was established to meet a need for practitioners to be able to prioritise an intersubjective, philosophically derived understanding of the human condition that the then Division of Clinical Psychology could not offer. This may no longer be the case. As Richards, former chair of the Division of Counselling Psychology notes, “both counselling and clinical psychologists are aware of the need for intersubjective relating; for reflexivity, and both use reductionistic approaches as necessary” (Richards, 2019). Continuing to emphasise the differences between the various Divisions of the British Psychological Society may indeed be ‘divisive’ (ibid, p.2) and perhaps it is now time we all call ourselves Applied Psychologists, albeit with special interests in ‘x’ or ‘y’. To speak of research contributions to counselling psychology, as contrasted to say clinical psychology, may therefore no longer be meaningful.

An argument for the unique contribution of this research to counselling psychology, flows from the principles upon which it is founded: 1. to engage with subjectivity and intersubjectivity; 2. to know empathically and respect first person accounts; 3. to be practice led, with a research base grounded in professional practice values as well as professional artistry; and 4. to recognise social contexts and discrimination and work in ways that empower (BPS, 2002). The current research sits squarely within this tradition, seeking to answer questions that have a particular focus on relational dynamics, with the aim of reducing stigma and discrimination towards ‘borderline patients’. It attends to social context, by moving beyond a narrow, inter-relational construction of findings, to include psychosocial factors at team and organisational levels.

Implications for practice flow from the qualitative and critical realist allegiances of the ontology and methodology, meaning a quantitative notion of generalisability is not meaningful. However, to consider ‘receptive generalisability’ and ‘utilisation value’ (Smaling, 2003) from the qualitative literature is appropriate. Receptive generalisability is a form of communicative generalisation (ibid, p.59) where much of the responsibility for determining the potential for generalizability is left to the informed reader. Readers are recommended to consider the ‘quality criteria for analogical reasoning’ (ibid, p.57-59), though still rely on the researcher having been transparent enough in their presentation of data, owning their perspective and situating the sample through narrative descriptions of the participants and the organisation (see Section 4.1 and Appendix 8). The reader is then well placed to consider the extent to which these findings ‘transfer’ to other analogical situations.

This research has explored an NHS Trust’s approach to what the literature describes as a particularly challenging group of patients to work with and where stigma and discrimination are prevalent (Dickens et al., 2016a; Dickens et al., 2016b). It makes observations at individual, team and organisational levels, with implications for practice flowing from each of these areas. The end point of this research suggests the need for the beginning of another form of analysis and intervention. It does this by extending ultimate causation for the processes studied outwards, to social and economic spheres, where a loss of human values at the centre of decision making is implied, negatively impacting the health and wellbeing of all (Carney, 2020; Marmot et al., 2010, 2020; Pickett & Wilkinson, 2010).

This research proposes that a psychodynamic framework should be applied to practice and training at all levels of this organisation, to usefully reframe the challenging experience of working with this patient group as meaningful communication, with supervision and training to support this shift in clinical focus. This would help reduce team burn out in situations where staff are prone to ‘not feeling able help’ or ‘wanting to be better at curing’ (Westwood & Baker, 2010; Woollaston & Hixenbaugh, 2008). By reframing these challenging feelings as meaningful therapeutic communications (Section 2.5 and Bateman & Fonagy, 2010; Freud, 1950) and supporting this understanding with matched supervision, an experiential paradigm shift becomes possible. This is a significant idea that could be applied to team and individual supervision immediately.

At an individual-level, my research constructed categories of ‘copers’ (Section 5.2), as well as a conceptually higher, more therapeutic way of relating to patients, that was considered ‘containment’ (Section 4.3.1). The lower level capacity of organisationally supported ‘coping’, maybe a significant finding of this research, by reducing stigma and discrimination towards borderline patients. This success has in-built limits in terms of the amount of therapeutic growth it allows and may even form part of the trajectory to eventual suicide, when experienced as ‘another failed treatment’. The introduction of weekly, expert group supervision underpinned by a manualised framework was found to be central in supporting copers to maintain this level of relational functioning and may be something other organisations wish to transfer to their contexts. However, whether this can be thought of as ‘therapeutic’, or is indeed part of a harmful repetition of a failure of adequate care is debateable.

With the higher-level capacity of containment, various factors were implicated in supporting staff to achieve this. These included: a history of personal therapy, or experience of therapist-led group supervision; control over exposure to patients through informal spaces & supervision, and transitional theoretical frameworks drawn from professional socialisations. These factors could be selected for, becoming qualities the organisation actively seeks when setting its culture. They could equally become criteria for selecting candidates for clinical roles, with money and time allocated to these as important priorities for ongoing training and investment.

A further important process used by contained staff, was striving to achieve ‘managed hope’ (Section 4.3.1, Theme 4). This may be a cognitive orientation that it would be possible to cultivate through training and guided supervision. This could be an interesting stand-alone intervention to explore in further empirical work.

In this research, a mixed picture of team-level functioning seemed to implicate funding shortages with more insular modes of coping and hostility outwards to other teams. More contained teams were organisationally supported by being ‘asked’ to tolerate less exposure. This was achieved through: group supervisory processes; the ability to take space; low or shared caseloads; a unifying theoretical framework and containing trauma from higher levels. However, overwhelming exposure from caseloads that were ultimately too high, had the ability to dampen or even collapse the processing function of reflective and supervisory spaces.

Thinking about society more broadly, in his recent Reith Lectures (2020), former Governor of the Bank of England Dr Mark Carney described the origin of modern economics as flowing from the philosophy of Adam Smith, where the market was designed to serve society’s values. Carney argues this has changed, with markets no longer serving human values, instead having become ends in themselves, where value is instead determined by short term consumer demand. He feels markets are now failing us and need radical reform, citing evidence of the banking collapse, impending environmental disaster and the disproportionate effect of covid-19 on the poor. This market model also underpins the NHS and links to the findings of this research, in that many parts of the Trust functioned as siloed teams, with little sense of being part of a group of people working together for their community; rather, there was an overload within individual teams leading to a rejection of any external requests for help that were experienced as a kind of attack. The mental health services’ mantra of ‘independence’ was relied upon to serve the same goal of reducing the ‘burden’ of time spent with any patient or part of the service. This construction seems unhelpfully atomistic (Aubyn, 1998; Camus, [1942]/2000; Durkheim, [1897]/2006; Hari, 2015; Houellebecq, 2001) and to mirror a dislocation of people in our capitalist society from their internal worlds more broadly (Bollas, 2018; James, 2007; Lasch, 1979).

Michael Marmot’s review of health inequality (2010, 2020) made similar points to Dr Carney’s. Marmot states, “there’s no point treating people only to send them back to the causes” (Marmot, 2020), highlighting how a lack of social justice is the main factor determining health differences in the UK today. Much the same is also true for poor mental health (Bentall, 2004; BPS, 2013; McManus et al., 2016; Pickett & Wilkinson, 2010), though the mental health system is additionally suggested to be contributing to the burdens for this group, by providing them with ‘cut-off’ workers and frankly insulting ‘therapy’ timeframes in the majority of cases (Marks, 2018; Rizq, 2012, 2014; Scott, 2018; Shedler, 2010, 2018).

Marmot and Carney both highlight a contemporary Britain where values are no longer the guiding principle for society’s decision making, where market forces dominate and services remain unequal and failing. This trend is reflected in my research, where an underlying theme of ‘independence’ is offered as justification for the economically based short cuts of CBT, Moving-On and CMHT work; and, where work involving longer term ‘boundaried dependence’ is marginalised. The short term is quantified, while the ultimate longer term causes are glossed away, in a revolving door of inadequate provision (Finn et al., 2000; Garrido & Saraiva, 2012; Seccula, 2016).

Current UK mental health services prioritise symptom reduction (BPS, 2013; Dillon, 2011) and ‘quick fixes’ (House & Loewenthal, 2008; Leader, 2009; Taylor, 2011), rather than addressing the deeper causes of suffering (Bentall, 2004; British Medical Association, 2020; Oliver James, 2007; Leader, 2009; Marmot, 2020; Pickett & Wilkinson, 2010). We need to update our conception of mental health and wellbeing, defining it more broadly, over longer time scales, understanding its psychosocial aetiology and valuing ‘the internal’ again. This requires meaningful integration of psychological, sociological and economic policy (British Medical Association, 2020; Health England, 2017; Seikkula, 2016; Shedler & Gnaulati, 2020) when seeking to understand and ameliorate the causes of mental suffering, which are as much socially as individually derived.

While our culture and NHS remain stuck, the role of counselling psychologists may be to ‘hold’ this difficult reality, understanding suffering as much through ‘developmental social justice’ as ‘individual dyadic psychopathology’, while championing appropriately longer treatment time frames and attempting to integrate work across siloed teams through a renewed focus on the internal world of the patient. Whether it is ethical to work within such systems seems an important question. If, instead of offering containing therapeutic experiences, clearly inappropriate interventions that patients will likely experience as ‘yet another failed treatment’ pave the way for their giving up, are we not then complicit by continuing to take part in such systems?

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APPENDIX 1. TRUST COLLABORATION LETTER

[redacted]
[redacted]

Christopher Woodgate
Assistant Psychosocial Practitioner
Trainee Counselling Psychologist
Honorary Psychotherapist

Department: Research & Development
Ask for [redacted]
Date 18/01/2018

Dear Chris

Re: A multi-informant, multi-perspective account of what helps staff ‘survive’ working with people with Borderline Personality Organisation

The [redacted] Partnership Trust are fully supportive the above project and are delighted to be able to support it. We can confirm that as NHS Staff research, it won’t require NHS Ethics review. I have already ask [redacted] our governance lead to advise you on any other approvals that may be required.

Patient and staff participation in research is a priority for us, and we think that both our staff will be interested in supporting, and taking part in this research.

Wishing you all the best with the project

Yours sincerely,

[redacted]
Managing Partner
Research & Development Team

Chair: [redacted] Chief Executive: [redacted]

[redacted]

APPENDIX 2. FREC ETHICS

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS.18.07.195

27th July 2018

Dear Christopher

Application title: What helps staff 'cope well' in the task of caring for people attracting a Borderline Personality Disorder Diagnosis: a qualitative investigation using a psychodynamic and systemic framework

I am writing to confirm that the Faculty Research Ethics Committee are satisfied that you have addressed all the conditions relating to our previous letter sent on 18th July 2018 and the study has been given ethical approval to proceed.

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: https://intranet.uwe.ac.uk/tasks-guides/Guide/writing-and-creating-documents-in-the-uwe-bristol-brand

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee. http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

The Faculty and University Research Ethics Committees (FRECs and UREC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance. Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher remains responsible for ensuring that the project complies with UWE's policies, and with relevant legislation. If you need help with legal issues please contact safety@uwe.ac.uk (for Health and Safety advice), James2.Button@uwe.ac.uk (for data protection, GDPR and privacy advice).

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please remember to populate the HAS Research Governance Record with your ethics outcome via the following link: https://teams.uwe.ac.uk/sites/HASgovernance.

We wish you well with your research.

Yours sincerely

Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c. *Nigel Williams*

APPENDIX 3. SCOPING E-MAIL

Research Request: What helps practitioners working with people with EUPD/BPD- Invitation to Interview

Dear Colleague,

I work for the Trust on a part-time basis while studying on a Psychology training programme. Part of this training involves doing research and writing a thesis.

I have worked on the wards and in the personality disorder service within Anonymous Partnership Trust for a number of years. During this time I have become interested in the impact that working with people with borderline personality disorder (/Emotionally Unstable Personality Disorder) can have on staff.

We know from the literature that this is a particularly difficult group to work with and that it takes a disproportionate toll on front line workers. I am interested in learning more about what helps to support people to cope in this work.

I plan to interview 12-16 people. I would be interested in people who feel they have a good degree of contact with the client group and would like to speak about their experiences.

I plan for interviews to be between 45-60 minutes long, with a loose structure of questions around which I would invite people to speak as freely and openly as they feel able.

The *identity* of interviewees would be kept strictly confidential and interviews can take place either at DPT offices, or outside of work, as people prefer. The *content* of the interviews *would* be used for analysis and quotes may be used in the analysis and discussion section of the thesis. If the research is published then these quotes may also appear in the published work.

I am now in a position to start interviewing, so please contact me if you are interested. The purpose of the research is to see what we can learn from the people doing the work, with a goal of identifying any factors that help. We will offer any learning forwards within the Trust and seek to disseminate more widely through publication.

Please contact me directly by email if you would be interested in taking part.

christopher.woodgate@nhs.net

Kind regards,

Chris Woodgate
Trainee Counselling Psychologist

Dr [redacted]
Consultant Psychologist,
Professional Lead Psychology

APPENDIX 4. PARTICIPANT INFORMATION SHEET

Hospital Staff Experiences of Working with People Attracting a Borderline Personality Disorder/ Emotionally Unstable Personality Disorder Diagnosis

Participant Information Sheet

Who are the researchers and what is the research about?

Thank you for your interest in this research on hospital staff experiences of working with people with a Borderline Personality Disorder /Emotionally Unstable Personality Disorder diagnosis. My name is Christopher Woodgate and I am a trainee psychologist in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my Doctoral Thesis. My research is supervised by Nigel Williams (please find his contact details below).

What does participation involve?

You are invited to participate in a qualitative interview – a qualitative interview is a 'conversation with a purpose'; you will be asked to answer questions in your own words. The questions will cover your experiences, feelings and ideas about working with this client group in the Trust. The interview will be audio recorded and I will transcribe (type-up) the interview for the purposes of analysis. On the day of the interview, I will ask you to read and sign a consent form. You will also be asked to complete a short demographic questionnaire. This is for me to gain a sense of who is taking part in the research. I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview.

Who can participate?

Anyone over the age of 18 with experience of working with this client group and who is interested in taking part.

How will the data be used?

Your interview data will be anonymised (i.e., any information that can identify you will be removed) and analysed for my research project. This means extracts from your interview may be quoted in my dissertation and in any publications and presentations arising from the research. The demographic information will be given a code to link it to the interview transcript and these will be analysed together. The demographic data for all of the participants will also be compiled into a table and included in my dissertation and in any publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

The personal information collected in this research project (e.g., the interview audio recording and transcript, and the demographic form) will be processed by the University (data controller) in accordance with the terms and conditions of the Data Protection legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. The data will be destroyed when the final output is accepted for publication. You have the option to consent to your anonymsed data being retained for an additional 3 years for further publications or research.

Your personal information will be used/processed as described on this participant information sheet. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, ordataprotection@uwe.ac.uk

What are the benefits of taking part?

You will get the opportunity to participate in a research project on an important social and psychological issue. The finding of this research will be offered to Devon Partnership Trust for their consideration and I aim to publish the findings.

How do I withdraw from the research?

If you decide you want to withdraw from the research please contact me via email christopher.woodgate@nhs.net. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

Are there any risks involved?

We don't anticipate any particular risks to you with participating in this research; however, there is [redacted]

Please note that in exceptional circumstances I have a duty to break confidentiality, such as if I have significant concerns for either your safety or the safety of patients you are working with.

If you have any questions about this research please contact my research supervisor: Nigel Williams, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

Email: Nigel3.Williams@uwe.ac.uk

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

APPENDIX 5: PARTICIPANT CONSENT FORM

NHS Staff Experiences of Working with People Attracting a Borderline Personality Disorder / Emotionally Unstable Personality Disorder Diagnosis

Consent Form

Thank you for agreeing to take part in this research on NHS staff experiences of working with people attracting a Borderline Personality Disorder /Emotionally Unstable Personality Disorder diagnosis.

My name is Christopher Woodgate and I am a trainee psychologist in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data collection for my Doctoral Thesis. My research is supervised by Nigel Williams. He can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY [Tel: (0117) 3281234; Email: Nigel3.Williams@uwe.ac.uk if you have any queries about the research.

Before we begin I would like to emphasize that:

- your participation is entirely voluntary

- you are free to refuse to answer any question

- you are free to withdraw within the limits specified on the information sheet.

You are also the ‘expert’. There are no right or wrong answers and I am interested in everything you have to say.

Please sign this form to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research:

___________________________ (Signed)

___________________________ (Printed)

_______________ (Date)

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

Please could you also indicate if you consent to your anonymised written data being retained for a further 3 years following acceptance of the published thesis for the purposes listed below by placing a tick in each of the boxes that apply. If you prefer for your data not to be retained and used in this way please place a cross in the box. Please could you also sign below to confirm your chosen preference.

Further research ☐

Further publications ☐

__________________________ (Signed)

__________________________ (Printed)

_______________ (Date)

Please return the signed copy of this form to me.

Researcher signature __________________________

Date __________________________

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

APPENDIX 6: DEMOGRAPHICS FORM

NHS Staff Experiences of Working with People Attracting a Borderline Personality Disorder / Emotionally Unstable Personality Disorder Diagnosis

Some questions about you

In order for us to learn about the range of people taking part in this research, we would be grateful if you could answer the following questions. All information provided is anonymous.

Please either write your answer in the space provided, or circle the answer, or answers, that best apply to you.

1	How old are you?			
2	I am:	Male	Female	Other - ________________ Prefer not to say
3	I am:	Full-time employed	Part-time employed	Full-time student
		Part-time student	Other - ________________________________ Prefer not to say	
3a	What is your occupation?			
4	How would you describe your sexuality?	Heterosexual Bisexual Lesbian Gay Other______________________ Prefer not to say		
5	How would you describe your racial/ethnic background? (e.g., White; Black; White Jewish; Asian Muslim)	____________________________		
6	How would you describe your social class? (e.g., working class; middle class; no class category)	____________________________		
7	Do you consider yourself to be disabled?	Yes	No	Prefer not so say

8	How would you describe your relationship status?	Single Partnered Married/Civil Partnership Separated Divorced/Civil Partnership Dissolved Other _______________________ Prefer not to say		
9	Do you have children?	Yes	No	Prefer not to say

Thank you!

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

APPENDIX 7: MOVING-ON PROGRAMME INFORMATION

The Moving-On programme is an 8 week intervention created by Anonymous Partnership Trust that is based on an 18 month control condition intervention called Structured Clinical Management (SMC). Bateman & Fonagy (2009) used SCM as a control condition to test Mentalisation Based Therapy (MBT), both candidate treatments for patients attracting a borderline diagnosis in outpatient community settings. The trial found MBT superior to SMC in all areas, with significantly greater reductions in self harm, hospitalisations and suicide attempts. However, SCM was found to have an initially greater reduction in self harming behaviour, thought ultimately less substantial. This faster initial reduction was speculated as potentially being due to the SMC's focus on problem behaviour rather than mental states in MBT.

During a series of Pathway meetings at Anonymous Partnership Trust, the Personality Disorder Pathway team identified that care coordinators were overwhelmed with personality disorder referrals and that there was inconsistent practice between teams. The adaptation of SCM into Moving-On was suggested at one such meeting as a way of providing a structured framework to assist care coordinators in delivering a more consistent service and to support them in feeling more confident. Moving-On was developed and then trialled as a pilot in a CMHT away from the Trust Headquarters. Following the success of the pilot, it was then rolled out across the remaining CMHT areas. Initial measurement of the pilot was managed by the team who implemented it. Following Trust wide implementation, assessment was removed from the local level. Decisions about how to assess are reportedly ongoing at higher levels in the organisation, with no data being available.

Interviewees for this research represented the Moving-On Programme as functioning predominantly as:

1. An initial assessment, with intervention for some patients, and
2. A gatekeeping mechanism for access to psychology for those unable to benefit from brief intervention at this level.

APPENDIX 8: RECRUITMENT & DEMOGRAPHICS

Participant	Personal information	Role
1	Gender: Male Sexuality: prefer not to say Ethnicity: White Class: Middle class Marital status: Married with children Age: 44 Pseudonym: Simon	Community Psychiatric nurse; full-time employed.
2	Gender: Female Sexuality: Heterosexual Ethnicity White British. Class: Working class Marital status: Partner and has children Age: 46 Pseudonym: Andrea	Nursing assistant/ student nurse; full-time employed.
3	Gender: Female Sexuality: Heterosexual Ethnicity White Class: Working class Marital status: Married with children Age: 47 Pseudonym: Clare	Clinical team manager/ registered mental health nurse; full-time employed
4	Gender: Male Sexuality: prefer not to say Ethnicity: White Class: Middle class Marital status: Married with children Age: 58 Pseudonym: Paul	Systemic psychotherapist/ social worker; employed part-time.
5	Gender: Female Sexuality: Heterosexual Ethnicity White Class: Middle class Marital status: Married, no children Age: 32 Pseudonym: Sue	Community mental health nurse; full-time employed.
6	Gender: Female Sexuality: Heterosexual Ethnicity White Class: Working class Marital status: Single, no children Age: 56 Pseudonym: Angharad	Psychiatrist; full-time employed
7	Gender: Female	Clinical

	Sexuality: Heterosexual Ethnicity White British Class: Middle class Marital status: Married, no children Age: 47 Pseudonym: Robin	psychologist; part-time employed
8	Gender: Female Sexuality: Heterosexual Ethnicity White British Class: Middle class Marital status: Married with children Age: 47 Pseudonym: Lena	Registered mental health nurse; full-time employed
9	Gender: Female Sexuality: Heterosexual Ethnicity White British Class: N/A Marital status: Married with children Age: 48 Pseudonym: Grace	Social worker/ senior mental health practitioner, full-time employed
10	Gender: Male Sexuality: Heterosexual Ethnicity: White Class: Middle class Marital status: Married with children Age: 54 Pseudonym: Richard	Manager NHS/ registered mental health nurse, full-time employed
11	Gender: Female Sexuality: Heterosexual Ethnicity White Class: Middle Marital status: Married, no children Age: 53 Pseudonym: Jules	Psychiatrist/ psychotherapy

APPENDIX 9.1: ‘NON-COPERS DATA’, SECTION 5.2

Simon: 57. “they’re just Bombarding you with they’re like day to day problems . . . I don’t feel that hopeful because I do really struggle”

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61. “Well the erm supervision weekly supervision really helps, because that gives you the erm, Reinforces the Framework that you should be working under. And it erm gives you like some uh guidance... for your next session as well”

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283. “I just don’t feel armed with what they want to dump on me”

Richard: 71. “there’s a great expectation that we have the answers and we don’t. We’re not trained and we’re not, (big exhale) given the skills to be able to do that”

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75. “You’re sort of battling against other things that are happening as well and then people not wanting to take ownership”

APPENDIX 9.2: ‘COPERS WHO AREN’T CONTAINING’ DATA, SECTION 5.2

Lena: 173. “But I think the 8 weeks helps me, the constant 8 weeks and knowing there’s a beginning and there’s an end”

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367. “There was a particular young girl that we literally had a ward open just for her. . . I’ve always been able to work quite well with them and I don’t know I suppose (laughing) I just seem to be attracted to that client group really. So I did actually have a job when I first qualified to go and work in that service but um, I chose to come up ere for the community job”

Angharad: 232. “My strength doesn’t lie with the long term therapies”

Robin: 430. “If you just try and push people with PD away then maybe that’s easier emotionally for you to manage, cos you’re keeping them at a distance. If I was in the crisis team then maybe I’d be doing the same thing”

Clare: 527. P “I suppose it’s different cos now, not having face to face that often
527. I Sometimes managers can feel quite stressed and like they’ve got a lot of their shoulders, it doesn’t strike me that you’re carrying a huge amount?
528. P No. I’ve got a nearly full team”

APPENDIX 9.3: ‘COPERS WHO ARE CONTAINING’, SECTION 5.2

Paul: 108. “I don’t see personality disorder as over there and I’m over here and there’s some kind of dividing line. I think it’s a continuum that we’re all spread out along somewhere”

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234. “I think if you can sit with your own discomfort and pain and not run away from it . . .then that enables me to be in the room with somebody and have quite clear boundaries, to know it’s not my stuff its theirs”

Andrea: 123. “And it’s unfair isn’t it to expect something from somebody when they’re barely holding onto their own existence, let alone trying to live up to my expectations. You know and that’s how I get through things, its by not putting on expectations and not feelin disappointed”

Jules: 6. “it’s hard when you’re working directly with very severe arm borderline personality disordered people to feel arm Effective (bright). So I think that’s probably one of the hardest things.”

Grace: 20. “To have somebody come in and say “wow, I felt really listened to, I felt you helped make sense of this…I’ve really appreciated what you’ve done”. Yer, just helping people make sense”

APPENDIX 9.4: THEME 1 DATA, SECTION 5.3.1

Andrea: 97. “It’s not my job to judge people, I’m not their parent. I don’t have these expectations from people...”

Jules: 57. “I think one of the mistakes can be to get too close, or become too attuned, because some patients respond either by needing to run a mile or to regress. So that’s one of the things that’s really hard to judge, ‘am I getting too close?’

Paul: 248. “I think it’s something about being able to sit with those extremes and I’d say a lot of the work I do with couples and families is just slowing things right down, 'let’s just think about what’s going on in your body’. Um, ‘let’s think about what’s going on right now’. So it can be very slow work at times”

APPENDIX 9.5: THEME 3 DATA, SECTION 5.3.1

Andrea: 211. “I don’t like to cry in front of people I just feel a bit pathetic and weak but that’s something to do with my own stuff from a long time ago”

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149. “I’m not a Psychologist I’m not traaained in that kind of thing, so you know I only know what I know in my own life experience”

Grace: 162. “I’m pretty good at recognising what’s stuff I’m bringing and what clients have left me with, where that’s triggering my things and where it pertains to my own life and experiences”

Robin: 639. “No, it erm, it was never a requirement of my training. When I did a Masters in CBT about 10 years ago, they would always encourage you to use the thought records, formulate your own stuff, but not actually accessing therapy”

Richard: 282. “Yeah it definitely gets home. It does go home, er, to the extent that I’ve just recently, I don’t know if it’s the right thing to say but anyway, I’ve self-referred to the local psychological therapies service. I’m doing a course on mindfulness”

Lena: 213. “I remember ..being on a ward especially full of personality disordered females erm and you would have at the end of every shift your handover. And therefore that would be a time to be able to reflect and make sure you’re not taking home all of that emotion that they can provoke or question”

APPENDIX 9.6: THEME 4 DATA, SECTION 5.3.1

Andrea: 117. “Some of them affect me, don’t get me wrong, sometimes I get very cross and angry but that’s because I’ve put my own expectations and my own set of values onto someone else. . . it’s unfair to expect something from somebody when they’re barely holding onto their own existence, let alone trying to live up to my expectations”

Paul: 264. “What surprises me is when you feel like you’re getting nowhere, is just how important you are as a therapist to people. I’ve finished in other places and really thought I had no relationship with the person and then they’re deeply upset when I’m leaving them and I’m thinking ‘Oh, Okay’. So I think we can underestimate how much exactly is actually going on in the room”

Grace: 527. “I have to respect her decision, she’s an adult with capacity. If that’s what she decides she has to do to survive, then who am I to say that she shouldn’t?”

Jules: 38. “that is probably the biggest thing that helps, is having arm the team. So in particular, I think the team functions to hold different aspects of the person”

Clare: 213. “Medication is not as effective with people with a diagnosis of personality disorder. I think therapy, the longer term solutions, work very well. But also if they’ve got the right support, and I don’t think that community services are set up anymore to provide that. That’s no fault of their own, it’s about recruitment and retention and not having the skilled people to be care coordinators I think”

APPENDIX 9.7: THEME 5 DATA, SECTION 5.3.1

Paul: 312. “Every client I work with doesn’t have personality disorder. But if they did, I think I’d probably be saying different things to you today. But I think more reflective space would be useful”

Andrea: 233. “Sometimes it can be a little like, ‘I just don’t want to talk about that person anymore’”

Robin: 789. “So as a supervisor of CMHTs, I don’t ever try and get them to take the defence down, because basically they’ve got to stick it back up again quickly. So that would be part of if, they had a smaller caseload, I think they’d have more thinking space more time to reflect and maybe more opportunity to think about how to use supervision differently. It’s all about the system isn’t it.”

APPENDIX 9.8: THEME 6 DATA, SECTION 5.3.1

Grace: 412. “having worked as an AMP as well, that’s the role really, to look at the holistic picture and to challenge the medical model if it looks like it’s trying to wade in and get a bit heavy”

Robin: 799. “I’d have everybody trained in DBT skills so that they can do something useful, if that’s what the person needs at that time”

Grace: 54. “So to me it [Moving-On] doesn’t feel collaborative. It feels like something we are ‘doing to’ them, just repeating those patterns of somebody having things done to them”

Angharad: 436. “DBT has a clear structure with clear procedures and I think for people with personality disorders, who often have not been well boundaried, that structure is actually enormously helpful”

Simon: 128. “Others don’t find it particularly interesting and then feel they’re very restricted in their practice because of the paperwork. But as I say, for me it’s an aid”

APPENDIX 9.9: ORGANISATIONAL THEME DATA, SECTION 5.3.2

Robin: 784. “There’s something difficult for those workers in knowing how to open up a bit psychologically about their own material. They’re so busy and feel so overwhelmed, it’s too risky for them to start thinking about the emotional impact that someone’s having on you, because you know, you’ve then got to go back out into the fray. So you’ve got to put the defences back up again to survive”

Clare: 484. [Team supervision figures] “Quite low actually. I think there’s 3 or 4 band 6s have got clinical supervisors identified, that’s out of a total of 13”

Richard: 340. “I think the pace is so fast that there is limited time to analyse that [impact on staff]. I think the idea was that would happen in the supervision with psychology, but there is just an overwhelming number of individuals to be discussed and so it doesn’t get time to be discussed”

Richard: 465. “it doesn’t necessarily have to be a manager; it could be a band 6 who wants to expand their knowledge and shine a bit you know, and just ‘what’s happening at the STC?’”

Lena: 213. “I think we should definitely have more so there is time to be able to reflect and make sure you’re not taking home all of that emotion that they can provoke or question.”

APPENDIX 10: SUMMARY ARTICLE

Title **What contains the containers? An organisational thematic analysis within an NHS Trust investigating what supports staff in their work with people attracting a borderline diagnosis.**

Introduction

People diagnosed with borderline personality disorder experience a ‘double dose’ of suffering. The chronic emotional pain and inner turmoil that is the result of their condition, compounded by stigma and prejudice at the hands of NHS staff they approach for help (Bodner et al., 2015; Dickens, Lamont & Gray 2016a). Interventions at an individual staff level have proven ineffective, with researchers suggesting further research might better target organisational and structural levels (Dickens, Hallett & Lamont, 2016b, p.125).

This insider research (Brannick & Coghlan, 2007; Crociani-Winland, 2018) builds on my experience working in one NHS Trust, across a variety of roles over an 8 year period. It takes a broadly ethnographic approach to a sequence of eleven interviews with staff working with borderline patients across the Trust, though in different teams, roles and having different professional socialisations. Interviews were analysed at individual and organisational levels, using a psychodynamic ontology (Armstrong, 2005; Hinshelwood & Skogstad, 2000; Hollway & Jefferson, 2013) & thematic analysis (Braun & Clarke, 2012) to provide a ‘binocular’ psychosocial synthesis (Richards, 2019). Data were triangulated with researcher observation and counter-transferential material. New knowledge is presented about what supports staff and teams to remain relationally connected to borderline patients, rather than detaching or becoming overwhelmed, when prejudice and stigmatisation become more likely.

Methods

Initial Thematic Analysis with binocularity

The interviews were first analysed individually, using an adapted version of Braun & Clarke’s (2006) Thematic Analysis. Thematic analysis is a versatile method, benefitting from being well specified in the literature and not imposing any particular theoretical framework. It instead provides a structural shell within which a theoretical core may be placed, in this case a psychodynamic ontology. Immersion in the data through extended familiarisation (Braun & Clarke, 2012; Clarke & Braun, 2018) was followed by multiple rounds of reflective reading some of which was shared with an external supervisor for their input and reflections. An emergent element of this process came from a more ‘bottom up’ approach, while some of it was more formed through integration of the data with organisational and psychodynamic theory. Following this extended process of orienting to the data, the following methods were developed to address the research questions:

Question 1 methods

The first question sought to understand team and organisational functioning. I relied on a tripartite framework, in order to approach this question from different angles. One part was a bottom-up analysis of the worker’s construction of the organisation through their organisation-in-the-mind (Armstrong, 2009). Another part involved organisational observations (Hinshelwood & Skodstad, 2000) by myself as an insider researcher. The final part was providing an initial commentary on the participant’s capacity to be fully present in the therapeutic relationship whilst at the same time being able to tolerate and think about this, or their ‘degree of containment’. This triangulation of data sources was supported by external supervisory input, a journal of transference and counter-transference observations and personal psychoanalytic therapy. A summary of interrelationships between the teams is presented in an organisational map (Figure.1).

The principles of: (i) researcher organisational observation and (ii) inferring the interviewee’s organisation-in-the-mind both involved relying on the use of: evenly hovering attention without premature judgement; subjective experience (sharpened as much as possible by personal psychoanalysis); the capacity to reflect and think about the experience as a whole; recognition of the unconscious dimension, and informed interpretation (Hinshelwood & Skogstad, 2000, p.17). The main difference between the two approaches lay in the intended object of inquiry. For organisation-in-the-mind assessments, judgements were made about another subjects’ likely constructions of the organisation. While with organisational observations, the goal was to notice my own constructions, in order to better take account of these when making organisational observations rooted in personal experience.

Differentiating my personal transference contributions from those made by interviewees was supported by maintaining a careful reflexive journal of transference and counter-transference observations, completed as soon as possible after each interview.

Question 2 methods

The second question explored which workers were ‘contained’ (Bion, 1962; O’Hara, 2013; Schore, 2012; Winnicott, 1960) and was achieved through a more top-down, theoretically driven analysis of interview responses.

I felt I needed to first understand who was ‘more contained’ and who ‘less contained’ in order to be able to make any meaningful comments about what supported people to do this at individual and/or organisational levels. I applied psychodynamic theory to individual interviews, to develop a model of contained practice for these participants. This analysis took account of any psychodynamic defences being used and the extent to which these predominate in the individual’s functioning.

Question 3 methods

The third question examined how participants judged to be contained in the previous section, achieved this. It relied on my application of thematic analysis (Braun & Clarke, 2012; 2018) to the interview transcripts of contained participants at multiple levels (individual and team/organisational), integrating other elements of the analysis so far, together with further theory.

Two ways of thinking about the data are highlighted through separate levels of analysis. They are separated out for clarity, but are nonetheless understood as reciprocally interacting throughout the processes that were researched and analysed.

1. One level explored individual, intra-psychic and inter-personal elements in order to highlight any strategies or qualities common to this group.

2. Another level focussed on the team and organisational elements and integrated analyses from the previous findings sections.

Analysis and Discussion

Question 1

I summarise this section of analysis in the form of an organisational map. Tentative relationships between the various parts of the organisation are presented, as are organisational observations (red) and organisation-in-the-mind inferences (green).

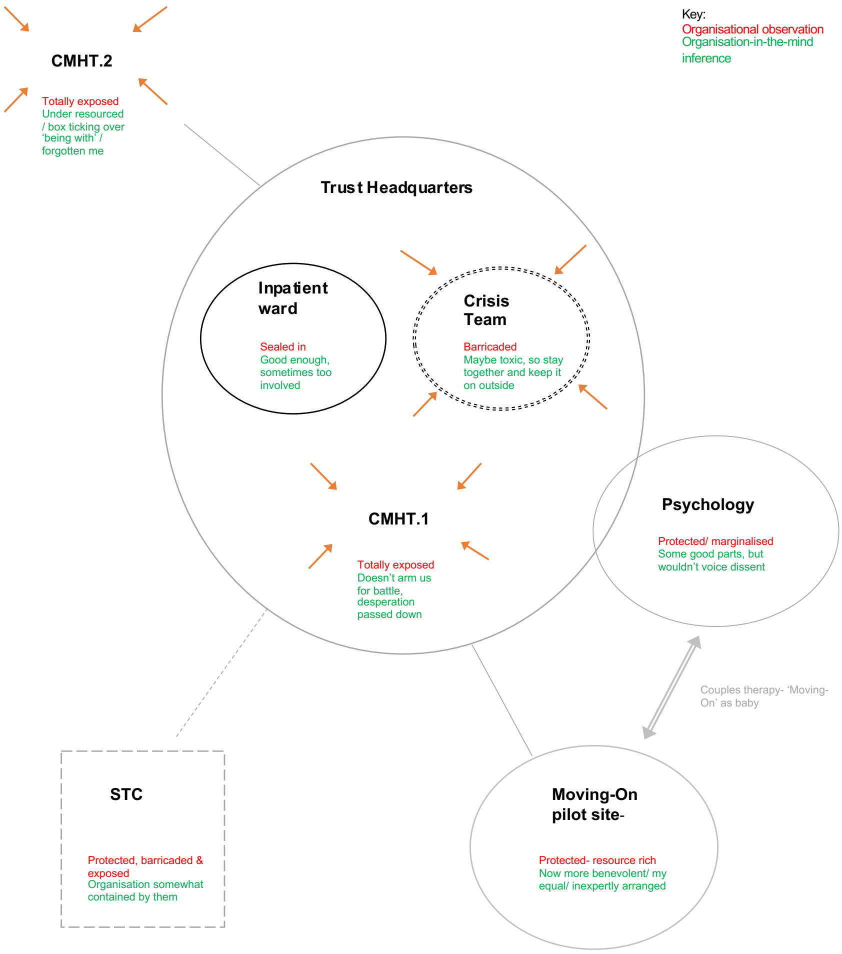

Figure 1- Organisational map

Question 2

This section of analysis is concerned with identifying individual-level containment; team and organisational-level containment will be considered in the Question 3.

I suggest that one necessary condition for containment is a certain degree of emotional involvement with the patient and that in order to achieve this staff must themselves be contained. Some staff in the research were suggested as not being ‘at sea’ as they were not emotionally involved enough with patients for this to unconsciously register in the patient as ‘containment’. Staff who use this strategy to cope, may do so through overreliance on theoretical models or by just maintaining relational distance, though with the same result, staff are protected from identifying too much with the patient’s disturbing internal world. At the other end of the continuum are staff who are too identified with the patients’ internal world, having become ‘flooded’ and who cannot cope at all. The following diagram illustrates how I have placed participants along a continuum of containment:

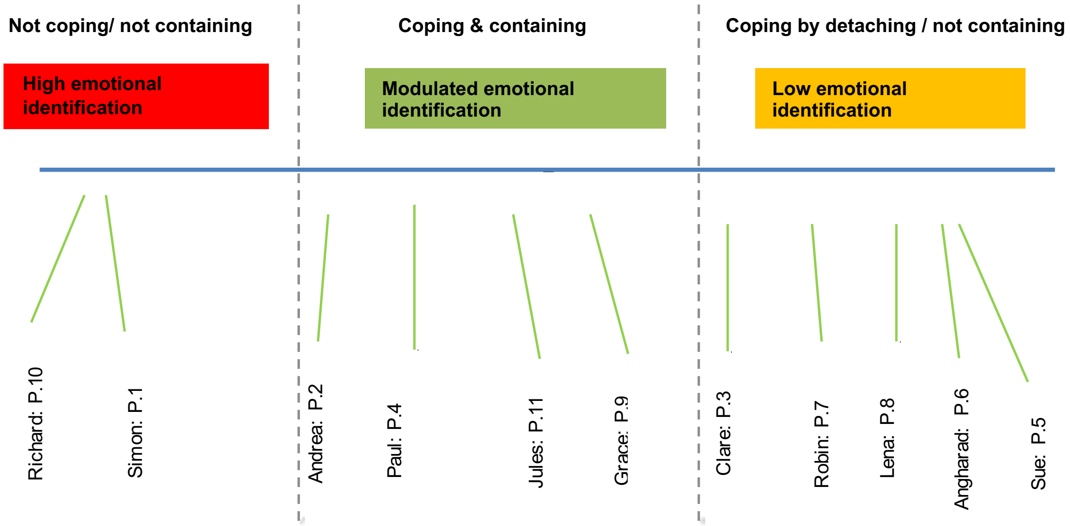

Fig.3 Continuum of containment

Question 3

The final section builds on the previous two, first exploring individual-level contributions to staff containment (Themes 1-6), before turning to organisational-level contributions.

Overview of individual-level themes

Two themes reflect complementary sides of one superordinate process for achieving close, yet boundaried therapeutic relationships with borderline patients. The two themes overlap somewhat with one another, as does the evidence that supports them. However, they do appear to have somewhat distinct qualities that merit their separation.

All four contained participants made reference to these processes, while copers who were deemed uncontained, only partially made reference to them:

A. Superordinate process

Theme 1:	Managing inter-psychic proximity - ‘empathic-adult’ position, &
Theme 2:	Tolerating relational pain, attacks and not-knowing – ‘negative capability’ (Bion, 1984).

There were also a series of other themes relating to things that supported contained participants to achieve this superordinate process:

B. Supportive factors

Theme 3:	Personal therapy, or experience of therapeutic group process work
Theme 4:	Managed hope
Theme 5:	Control over exposure & informal spaces, &
Theme 6:	Transitional frameworks drawn from professional socialisations

Examples: A. Superordinate process

Theme 1

Grace provides a good example of how hard tolerating the adult-empathic process can be, when describing a patient of hers who drinks bleach. Here, Grace resists pressure to merge and take too much responsibility for the child-like part of the patient's destructive behaviour whilst at the same time not defensively cutting off either while under considerable pressure in the relationship:

> Grace: 549. "There's nothing I can do about her drinking bleach. I know that I have to accept it. I have to respect her because that may be all I can bring to that particular element, to say, 'Okay, you are an adult that has a choice. You may well have been a child who didn't have choice, but I'm not gonna repeat that pattern'"

On the inpatient ward Andrea, strategically deploys defences in the service of sustaining a balanced closeness in her therapeutic relationships. Andrea consciously defends herself against taking too much responsibility, recognising this would lead to her getting 'sucked dry' and 'burn out'. She modulates her inner exposure to the patient using elements of a cutting off strategy, though this doesn't take over to become her core way of relating and is instead used in the service of being able to stay more connected over the long term.

Theme 2

Grace and Andrea both offer compelling examples of this 'negative capability' (Bion, 1984; French & Simpson, 1999). Grace, when remaining emotionally connected to a patient drinking bleach (above) rather than retreating from them or becoming overinvolved. Andrea, when working hard to tolerate the feelings elicited in her by a patient who self-harms when she leaves them, rather than angrily blaming them, rejecting or stigmatising them.

> Andrea: 87. "I can spend two hours talking with somebody, go off to the toilet come back and they've been cutting at themselves and ligaturing. It's like 'Oh my g.word'. I just think for those two hours I was sat with them they weren't doing that, so in a way I've done a good job. . . "

Examples: B. Supportive factors- themes 3-5

Theme 3: Personal therapy or experience of therapeutic process work

All of the contained participants had experience of personal therapy or therapeutic process work:

Paul: 110. "I think what sustains me as well if I'm honest, is I have had to go through therapy myself and had to look at quite a few of my early experiences and ah that gives me hope as well"

Theme 4: Managed hope

A process of maintaining a more realistic, managed form of hope supported the work of contained participants. This appeared to be an active, conscious process:

Andrea: 33. "I have hope that people will make a certain type of recovery"

Holding this kind of hope is challenging and seems to involve a decision to sit with the disturbing actions of the patient, not becoming over-identified and over-involved:

Jules: 6. "I feel that's probably the biggest impact. It's hard to feel like you've really been able to make a difference, or you know, you make some gains or some changes and then it's very easy for them to fall apart and then not hold onto them. . I feel sometimes it's easy to lose hope"

Theme 5: Control over exposure & informal spaces

Being able to manage exposure to patients and having informal spaces for respite was important for contained participants. While this is an individual level process, it is also an organisational one, in that the organisation may support or hinder access to it.

Paul: 274. "I need a lot of reflective space for myself, so I make a point of getting that and sometimes I walk out of the building to take space."

Theme 6: Transitional frameworks drawn from professional socialisations

A final theme was how people conceptualised their work and this linked to having a theoretical framework. It seemed that while having a theoretical framework was neither necessary nor sufficient for achieving containment, it did scaffold coping and was often involved in containment, when not overly relied upon.

Overview of organisational-level theme

One overarching theme (theme 7) of ‘team exposure’, was constructed from patterns within and across the data. Team exposure expresses the degree of ‘relational exposure’ the organisation implicitly requires staff to have with patients, relative to the structures and practices it provides that offset this.

The organisation could intervene to reduce team exposure and mitigate against staff becoming overwhelmed, or using ‘cut off’ defences by: 1. reducing caseload sizes; 2. offering training in theoretical systems (transitional frameworks), and 3. giving staff control over exposure to the work, through informal spaces and reflective spaces. Three new groupings of context seem possible that make sense of common processes they share:

Context 1

The inpatient ward is suggested to be a stand-alone context. It was presented as organisationally contained through good leadership, reducing the possibility of a defended culture (Menzies-Lyth, 1960) by shielding ward staff from anxiety (about targets, or capacity) that were being contained at higher levels (Long, 2018; Lucey, 2018).

Context 2

The crisis team and STC may be seen as forming a second context, sharing unexpected similarities as well as significant differences. Prejudice and stigma towards borderline patients were most clearly identified in the crisis team, this being alluded to in participant dialogue and organisationally observed. A common process that both the crisis team and STC engaged in was suggested to be taking place, defensively making referring-in, or having open communication with other teams difficult.

Context 3

The CMHTs, psychology team and the Moving-On pilot site can be thought of as a third, conceptually linked context via the Moving-On Programme. This was suggested to be an organisationally containing intervention that may have helped to reduce stigma and discrimination towards borderline patients. It did this by reducing team exposure to overwhelming practical demands from patients, as well as by providing a regular space for staff to process unconscious projections through weekly supervision.

Conclusions

At the individual level, the concept of therapeutic-level ‘containment’ was operationalised from theory and applied to the interview material. This was contrasted with the less therapeutically informed ‘coping status’, to form a continuum of containment. Higher level, therapeutic ‘containment’ was found to exist relatively independently of organisational factors, while lower lever ‘coping status’ was strongly supported by organisational factors.

Contained staff relied on a superordinate process to sustain therapeutic-level relationships with patients. This process involved: 1. the capacity to manage inter-psychic proximity- the ‘empathic adult’ position’, and 2. the capacity to tolerate relational pain, attacks and not knowing- ‘negative capability’ (Bion, 1984). This key process was supported by a number of factors: a history of personal therapy, or experience of therapist-led group supervision; staff actively working to achieve ‘managed hope’; control over exposure to patients through informal spaces & supervision, and transitional frameworks drawn from professional socialisations (Bell,1990 [Main, 1966]; Winnicott, 1953).

At the group level, some teams were traumatically organised, while others functioned better. Interestingly, teams could be traumatically organised while seeming to cope well internally, through the use of social defences such as ‘barricading’, that pushed disturbance back out into other teams and patients.

Traumatic team organisation could be mitigated by the organisation via managers, supervisors and wider organisational culture, through: reduced caseload sizes; providing theoretical frameworks; not passing on trauma from higher levels in the organisation, and giving staff control over exposure to the work through informal spaces, balanced with access to expert supervision.

This research suggests that Trust implementation of a manualised, time-limited intervention to help overwhelmed care coordinators was an organisationally containing act, supporting staff ‘coping status’ and protecting patients from the extremes of staff stigma & discrimination. However, insufficient funding meant the programme did not give staff sufficient time to reflect on feelings generated by the work. In this way, the programme functioned as a psychosocial bridge between social policy and staff internal functioning, inadvertently codifying emotionally dissociated ways of relating to themselves and others that discouraged therapeutic-level relationships. These treatment priorities may express and import a wider, market based culture of narcissistic self-reliance, where value is not attached to inner experience.