

# A PHENOMENOLOGICAL ANALYSIS OF THE CRISIS ENCOUNTER BETWEEN THE MENTAL HEALTH NURSE AND SERVICE USER WITH COMPLEX EMOTIONAL NEEDS

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## RESEARCH OBJECTIVE

A solid evidence base regarding the impact of Crisis Resolution and Home Treatment (CRHT) teams on service user experience is still lacking. Further, while research is emerging, there remains an inadequate focus specifically upon the experiences of those delivering and receiving care specifically for service users with complex emotional needs (CEN) within CRHT settings. This research study aimed to fill this research gap.

## METHOD

This study used hermeneutic phenomenology to examine the lived experience of both those providing and receiving care in within CRHT settings. Data were gathered via in-depth semi-structured interviews with 14 participants (7 mental health nurses working within CRHT settings, and 7 service users with CEN who have received CRHT intervention). Transcripts were analysed using Max van Manen's reflective phenomenological method (1990).

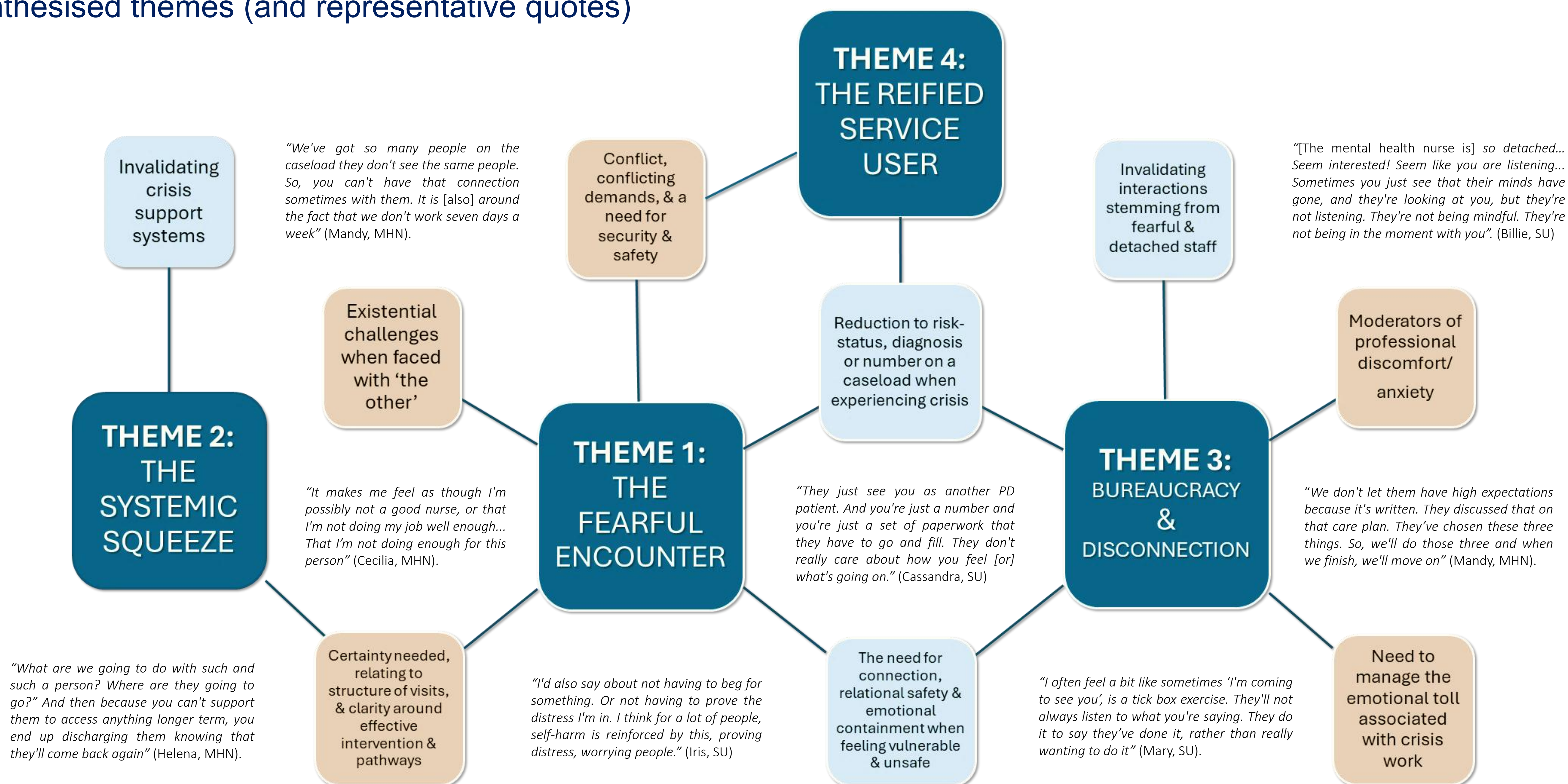
## van Manen's reflective phenomenological method (1990)



## FINDINGS

Interpretation and a synthesis of experiential accounts across both participant groups revealed several areas of convergence, thus highlighting those 'core structures' of mental health crisis care from the perspectives of both those delivering and receiving this. At the core of this interpretation and synthesis, fear and anxiety as arising from structural vulnerabilities are illuminated as the 'essence' of the crisis encounter in CRHT settings.

### Synthesised themes (and representative quotes)



### Fear as the *eidos* or 'essence' of the crisis encounter

<p><b>Identifying the 'regional essence'</b></p> <p>... thus, demarcating the fearful encounter from encounters experienced in other mental health settings.</p>	<p><b>Temporal urgency:</b> While acknowledging that fear and anxiety are not necessarily unique <i>per se</i> to CRHT settings, the intensity to which this is experienced is amplified. Fear is unmediated due to the acuity of the crisis.</p> <p><b>Lack of a relational buffer:</b> Unlike long-term teams (such as a CMHT), CRHT involves an element of 'unfamiliarity'. Especially where there is a lack of history between worker and service user, there is a lack of relational buffer softening the initial fearful impact.</p> <p><b>The absence of a spatial container:</b> Without the physical constraints of a ward, there is a lack of physical/institutional containment.</p> <p><b>The nurse as the sole 'living boundary':</b> The lack of physical and temporal boundaries in CRHT settings means that the nurse's own body and presence become the sole structural support; the <i>de facto</i> source of containment, thus exposing the nurse to vulnerability. For both parties, this is what makes the fear felt so acutely, thus setting the scene for the fearful encounter.</p>
<p><b>The test of invariant structure</b></p> <p>...thus, confirming fear as the <i>eidos</i> or as 'essential' to the crisis encounter</p>	<p><b>Confidence as a moderator:</b> Mental health nurse confidence does not necessarily disprove the presence of fear. Instead, confidence may be viewed as a moderator of, or a mode of 'being-with-fear'.</p> <p><b>Confidence as a form of detachment:</b> Data indicate that confidence is either an outcome of experience and learning to manage/contain personal anxieties, or conversely, is a form of professional detachment. This indicates that fear is indeed a default state of the crisis interaction.</p> <p><b>The fearful service user:</b> Regardless of whether the mental health nurse is experiencing a state of fear, the service user brings their own states of fear to the encounter, thus providing this essential component. Without this fear, the encounter dissolves into little more than a routine clinical interaction.</p>

## CONCLUSIONS

In establishing the notion that fear constitutes the *eidos* (or the 'essence') of the crisis encounter, this research offers some insight into why relational dynamics within CRHT settings are sometimes difficult to navigate. Where this encounter fails, it is not necessarily due to individuals alone, but because the system propagates a state of **reciprocal insecurity**; whereby both parties' attempts to secure their own safety within the encounter, inadvertently (and paradoxically) threatens that of the other.

Building upon our 2024 qualitative evidence synthesis (Haslam, *et al.* 2024), findings here provide some critical food for thought, specifically around how the pursuit of professional safety using bureaucratic tools, and through leaning into policy and the evidence-base do not just serve a performative role. These can also be considered **ontological evasions** employed by the mental health nurse to escape those emotional demands of the encounter, especially where their bodies become the sole source of containment. The use of such body-object approaches, however, mean that the service user is inevitably **reified** (as their diagnostic label, or risk status), and their epistemic accounts invalidated; inadvertently contributing to their heightened distress.

Findings, here, therefore highlight an urgent need for structures that provide the emotional space and the containment necessary for both parties to feel safe.

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