On Reciprocal Insecurities and Ontological Evasion:

Understanding the urgent need for phenomenological supervision and reflection in crisis care

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Despite decades of policy promises, the shortcomings of mental health crisis care in the UK are well-documented. As well as gaps in service provision (Centre for Mental Health, 2025; Trevillion, *et al.* 2022), the literature consistently highlights reports of clinical detachment and an overreliance upon those bureaucratic tasks aimed at monitoring risk (Averill, *et al.* 2024) which are often experienced by service users as being invalidating rather than containing. Specifically, for those with Complex Emotional Needs (CEN), structural inequalities, manifesting as a lack of relational care are also highlighted (Trevillion, *et al.* 2022), often being ascribed both to therapeutic pessimism, and to stigmatising attitudes (Foye, *et al.* 2022).

Arguably, however, pinning these failures of mental health crisis care solely upon those who deliver it oversimplifies this issue - overlooking both the emotional toll of working within hostile neoliberal healthcare systems and the nuances of complex, bi-directional anxieties arising at the clinical frontline. While Warrender (2024) has certainly come close in his description of confused and anxious crisis systems (citing the lack of clear models of intervention and systemic risks linked to the fear of litigation as key contributors), I contend that a further shift is needed to consider how *macro*-systemic anxieties are operationalised at a *micro* level. Understanding these issues - and indeed, *how to resolve them* - requires us therefore to re-focus upon those reciprocal relationships which define the crisis encounter itself.

Reciprocal insecurities as a defining feature of crisis care

Findings from our recent phenomenological study exploring the delivery and experience of Crisis Resolution and Home Treatment (CRHT) care for people with CEN (Haslam, *et al.* 2026) highlight those fears and anxieties arising from structural vulnerabilities as the 'essence' of the mental health crisis encounter. While acknowledging that these anxieties alone are not necessarily exclusive to CRHT settings, the acute and unmediated nature of service users' crises, augmented risk, and the intensity of the encounter mean that fears here are already heightened.

Furthermore, unlike other mental health services, CRHT settings often lack both the containing nature of existing therapeutic relationships, and the physical containment provided by inpatient hospital walls. As such, it is solely the nurse's presence providing the structural support and source of emotional containment for the service user. For the nurse, this exposes them also to a sense of professional and personal vulnerability; first, from the looming dual shadows of litigation and coroner's court, and second, from the '*self*' becoming exposed to the raw and unmediated suffering of another that they feel powerless to fix.

As my co-authors and I previously noted (Haslam, *et al.* 2026), such a position can lead to a sense of *reciprocal insecurity*; a relational manifestation of fear and anxiety, and a paradoxical, self-perpetuating loop whereby each party's attempts to achieve a sense of safety and containment have the potential to call forth further discomfort or a *dis-ease* in the other. For example, the nurse's leaning into bureaucracy, objective measures and policy to '*manage*' the service user and their risk, may be experienced by the service user as professional detachment. Feeling then invalidated by the nurse, the service user's need for containment is intensified, and so potentially increasing their expressions of distress. To the nurse, however, the service user's heightened distress merely provides confirmatory evidence of risk to be managed, thereby forcing the nurse to lean more heavily into bureaucratic control. Ultimately, fear breeds fear. No longer belonging solely to either individual, this emerges as a property of the '*inter-world*'.

Building upon our 2024 qualitative evidence synthesis (Haslam, *et al.* 2024), therefore, which established a pattern of clinicians distancing themselves from service users, our 2026 research study further suggests that this occurs due to shared (although differently expressed) experiences of fear, and the nurse's direct avoidance of the service user's *distress-as-lived*. Echoing the seminal findings of Menzies-Lyth (1988), we were thus able to frame such professional distancing - as in the mental health nurse's preoccupation with contextual or systemic issues over the relational encounter - as *ontological evasion*: a defensive survival mechanism functioning to protect the professional self from the emotional demands, and existential discomfort of the crisis encounter.

A case for hermeneutic phenomenological reflection

In a system that reduces the reflective capacity of those existing within it, I restate our call for hermeneutic mediators (Haslam, *et al.* 2026), or 'sense-making' devices, allowing the mental health nurse to step outside of the crisis encounter and to reinterpret this from a broader perspective. Doing so expands understanding of both their own and the service user's emotional responses, thereby mediating reciprocal insecurities in practice.

Hermeneutic mediators function by restoring the nurse's capacity for mentalisation (as in the ability to interpret one's own and others' behaviours through attention to their underlying mental states). Bateman and Fonagy's (2004) framework is useful here, explaining how a loss of mentalising capacity can have a direct impact upon interpersonal dynamics. While Bateman and Fonagy's notion of mentalisation was originally conceptualised for those diagnosed with a borderline personality disorder, arguably this has an equal and valid application to those nurses who hold diagnostic prejudices around the clinical other. The use of the term 'attention-seeking', for instance, when employed pejoratively to describe a person's help-seeking behaviours, perhaps tells us less about the person, as it highlights a reduced mentalising capacity in the nurse using it. Conversely, accurately interpreting one's own and others' behaviour within the context of current emotional and mental states, will likely have a more positive effect upon said behaviours and responses.

In clinical practice, the suspension of the nurse's prejudices and increasing processes of mentalisation can be addressed in a variety of different ways: those more obvious methods employing reflective supervision, reflexivity, and formulation-based approaches, all of which contribute to increased personal insight and understanding. Granted, while these are not new ideas, supervision in particular has become subverted for many within under-resourced neoliberal healthcare systems. Focusing instead upon task-orientated aspects of the role (as in the completion of mandatory training and meeting team and individual targets) it likely *reinforces* rather than *resolves* reciprocal insecurities within a team.

Alternatively, for supervision to be successful, I argue that a hermeneutic phenomenological lens must be applied, allowing this to become a space for intersubjective and intercorporeal attunement between supervisor and supervisee, and essentially modelling those relational practices necessary for supporting those in crisis. Such a shift requires a radical departure from current norms within health organisations: the supervisor's role shifting from that of compliance-monitoring to a skilful co-interpreter of the supervisee's own lived experience.

Drawing here upon the works of Bion (1962), for supervision to become a containing process for the nurse's experiences of fear and anxiety, it must first provide a phenomenological 'holding' space where reciprocal insecurities are recognised, described, and dissected. For instance, in validating the embodied and visceral responses of the nurse, this acknowledges anxieties and a physical tension as valid phenomenological data for reflection. Also, in naming and describing their ontological evasions (the nurse spending time talking to the service user about resolving their housing issue, for instance, over sitting with their distress or discussing their suicidal ideation), the nurse is permitted to explore these.

Furthermore, challenging the nurse to consider those things that were *unsaid* within the crisis encounter is vital especially where the use of clinical jargon, serves merely to distance the nurse from the service user's lived and visceral experiential accounts of crisis. Asking the nurse directly, "*What* – or w*hom - did you evade today?*", not only brings forth to consciousness and supports an interpretation of a person's countertransferences and emotional responses (thus allowing meaning to naturally emerge), but this also acknowledges how a person's ontological evasions serve as natural defenses against the angst of mental health crisis work, rather than being resultant of personal failure. Such methods of hermeneutic phenomenological reflection, however, would allow the nurse to re-enter the intercorporeal space with the service user with an increased awareness of their own ontological evasions and their impact.

Concluding thoughts

Our recent research findings (Haslam, *et al.* 2026) explain why crisis encounters, particularly with people with CEN, can sometimes be difficult to navigate. Issues result less from personal failure than from systemic pressures - the system itself not providing the reflective space necessary and so essentially failing *both* parties. Concluding this paper, I therefore contend that now more than ever, there is an urgent need to reclaim supervision as a method of hermeneutic mediation within mental health crisis care, especially where a sense of reciprocal fearfulness dominates – and *drives* - the crisis encounter.

While acknowledging that addressing reciprocal insecurities within the crisis encounter is no substitute for broader structural reform, it is arguably through the understanding and dismantling of systemic fears at a micro level that we mount a frontline resistance to systemic dehumanisation and restore relational connection. By doing so, we actively subvert the invalidation perpetuated by the 'othering' tendencies of neoliberal healthcare systems, and we can finally take steps toward delivering on those long-overdue promises of compassionate crisis care for people with CEN.

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