When recovery is not possible:
Forensic psychiatrists and serious offenders suspended in time

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Abstract

The pursuit of professional values is central to maintaining one's sense of self (Wright et al., 2017), but when this is hampered it can provoke strong emotional responses. Health professionals have a duty to act in a way which maintains the public's trust in the profession (Fotaki, 2014) subordinating their own interests to those of patients/clients and the public (Saks, 1995). However, such interests may be steeped in ambiguity (Swedberg 2005) and balancing public, client and professional interests can be difficult. This paper examines the ways in which professionals maintain their sense of self in their everyday practice and how they go about discerning what constitutes 'best interest'. Our findings offer two substantive contributions. First, we contribute to the study of professions by advancing understanding of the relationship between professions and interests, illuminating the nature and dynamics of the problems faced by professionals in ambiguous contexts. We do so by focusing on the less obvious affective processes often operating at a fantasy level. This is an important contribution offering a richer account of professional behaviour to contrast with the power and self-interest explanations which have dominated the professional behaviour literature for many years (Wright et al. 2017). As part of this we show the importance of conceptualising 'interest' in a way which incorporates emotional factors, going beyond the tendency in the literature to focus on conscious and rational motivations of professionals. Second, we contribute to the literature on professions and emotions providing a more nuanced description which is not focused on episodic emotional responses triggered by specific incidents but aims to provide an account of the complex ways in which fantasy and professional discourses evolve over time, to demonstrate the importance of emotions as an ever-present feature of professional behaviour and identity.

I have one particular person who has either been in prison or medium secure for 27 years. However, that guy has an extremely severe personality disorder, extremely severe mental illness. He has committed one murder and two attempted murders... I personally do not see this as a problem…It becomes a problem if you are not able to offer appropriate treatment. We do offer appropriate treatment…. even if someone's been there for twenty years you should still be trying to do something even if it's on a very sort of basic level … you may not be doing actual psychological treatment but you could still be working with an occupational therapist …looking at behaviours, communication skills or whatever it is …..we all pay lip service to the fact that we do .. every six months [a] review [for patients who are not going to move on]….you can't just put a statement up, 'this person in long term medium secure'….I'll adjust the treatment as best as I can as I go and if they need to stay they need to stay…Everybody knows [this patient won't be going out] yes, well we even probably do talk about it, but you just have to keep reviewing their care ... and what was a hopeless situation a couple of years ago you can review that person and say well actually they have made some progress. ID3.

Introduction

Health professionals have a duty to act in a way which maintains the public's trust in the profession (Fotaki, 2014) subordinating their own interests to those of patients/clients and the public (Saks 1995). However, such interests are defined through political and normative processes, which are rarely straightforward or even rational (Fotaki, 2010) while implementation failures in public health policy are not uncommon (Fotaki and Hyde, 2015). Health professionals and more specifically doctors, may be unable to deliver what is expected of them through no fault of their own. As they often operate in complex organizational environments where moral ambiguity and value conflicts disowned by the rest of society (Hoggett, 2006) are rife. The pursuit of professional values is central to maintaining one's sense of self (Wright et al. 2017), but when this is hampered it can provoke strong emotional responses amongst professionals (McNeil et al. 2013; Zikic and Richardson 2016).

Responding to problems which create strong emotional responses takes time and effort (Wright et al. 2017) and involves an assumption that the professional is easily able to judge what constitutes their client's best interests. However, such interests may be steeped in

ambiguity (Swedberg 2005) and balancing public, client and professional interests can be difficult, particularly, when professional norms concerning acceptable regimes of treatment and care have drastically changed as is the case of mental health. The context of ambiguity concerning organizational, client and public interest creates tensions for professionals, making it difficult to pursue professional values. Taken together, these issues raise a puzzle which we seek to explore in this paper. What do professionals do in such circumstances: do their practices change over time, how do they maintain their sense of self in their everyday practice, and finally, how do they go about discerning what constitutes 'best interest'?

Such questions raise an important issue because societal benefits flow from professionals acting in a way which prioritises the interests of others and supporting professionals grappling with difficult contexts is in the public interest. Despite this, calls to investigate "how the professions may retain normative value" (Muzio, Brock, & Suddaby, 2013: 703–704) have prompted limited scholarly exploration of the subject. Furthermore, consideration of 'interests' in relation to professional behaviour has often treated them as unproblematic and self-evident (Swedberg 2005). We investigate our research questions using a case study from the field of forensic psychiatry in England. This setting concerns mentally disordered offenders who are treated in enclosed facilities where government policy ostensibly aimed at curing and returning these patients to the community is at odds with the reality of patients with poor prognosis who remain hospitalised for most of their lives. By analysing our data, we identified the ways in which professionals coped with the challenge of ambiguity and maintained their sense of self in their everyday work. Our analysis reveals that in a highly emotionally charged and ambiguous context, professionals grapple with tensions and uncertainty regarding their own views and practice in relation to patient and public interests. They initiate changes to the content and context of care so that this is more aligned with one particular view of patient interest. As part of this process, temporal resources (the past, present and future) are used by professionals to construct and maintain a coherent sense of self. In a context of ambiguity, professionals' actions simultaneously diminish and trigger unpleasant emotions. Specifically, doctors negotiate their professional identity as they move away from the notion of recovery for long term patients towards improving their conditions, which implies scaling-down their expectations and reframing them in terms of care as opposed to cure. However, rather than providing neat explanations or adopting conscious rhetorical strategies to explain the prioritisation of certain views of patient and public interests over others, doctors' accounts can be read as contradictory and apparently irrational. To understand why this should be the case, we suggest that we need to go beyond surface accounts to uncover emotional dynamics which may not be amenable to conscious articulation. We therefore draw on psychodynamically informed literatures

particularly the work of the philosopher, Judith Butler on subjectivity, Lauren Berlant, a cultural theorist on the temporal dimension of fantasy, and a therapist turned researcher Lisa Baraitser, on the psychic experience of the suspended time. We use these to complement existing studies of professionals and emotions in organisational life.

Our findings offer two substantive contributions. First, we contribute to the study of professions by advancing understanding of the relationship between professions and interests, illuminating the nature and dynamics of the problems faced by professionals in ambiguous contexts. We do so by focusing on the less obvious affective processes often operating at a fantasy level. This is an important contribution offering a richer account of professional behaviour to contrast with the power and self-interest explanations which have dominated the professional behaviour literature for many years (Wright et al. 2017). As part of this we show the importance of conceptualising 'interest' in a way which incorporates emotional factors, going beyond the tendency in the literature to focus on conscious and rational motivations of professionals. Second, we contribute to the literature on professions and emotions providing a more nuanced description which is not focused on episodic emotional responses triggered by specific incidents (cf Wright et al. 2017) but aims to provide an account of the complex ways in which fantasy and professional discourses of cure versus care evolve over time, to demonstrate the importance of emotions as an ever-present feature of professional behaviour and identity.

Theoretical background

Professionals, subjectivity and temporality

Various studies examine the impact of 'identity threat' on professionals with many highlighting interprofessional rivalry as a cause of threat (e.g. McNeil et al. 2013). This implies a degree of self-interest amongst professionals and resonates with sociological literatures which have long emphasised turf battles between professionals motivated by the pursuit of wealth, status and power (Wright et al. 2017). However, 'identity threat' has also been linked with burnout where this threat is associated with feelings of low personal accomplishment (Lesage, Berjot, Altintas, et al. 2013). This suggests that we need to pay attention to the painful emotions which threaten professionals' sense of self and to understand how and to what extent these might be mitigated. This literature is useful in highlighting the ways in which professionals can feel threatened by failure to achieve their goals. However, for our purposes of understanding the everyday work of professionals in ambiguous contexts, we needed a concept which encapsulated the unconscious processes relating to 'feelings of low personal accomplishment'. Furthermore there is a need to go

beyond survey responses of atomistic individuals to a more socialised and relational view of the self.

To complement existing studies, we draw on Judith Butler's (1990; 1993) psychoanalytically informed approach which views subjectivity as constituted through recognition by others (Butler 1993). This perspective is informed by Lacan's ideas of individuals as existing only in relation to an important other (the people who care about us in early life) with whom we form libidinal ties that are then transferred onto the big Other (representing a given symbolic order, Lacan 2006). Butler draws on a key Lacanian concept of the individual's desire for recognition in the symbolic order to explain how our own precarity binds us to others. For Butler, it is a precondition of our own literal and symbolic survivability:

> If I seek to preserve your life, it is not only because I seek to preserve my own, but because who 'I' am is nothing without your life, and life itself has to be rethought as this complex, passionate, antagonistic, and necessary set of relations to others. (Butler, 2009)

Her reframing of subjectivity in relational terms has important implications for the ways in which we consider the everyday work of professionals. Discourse, since it 'precedes and enables the constitution of subjectivity' (Butler, 1993: 225), is also important here. Butler's understanding of the human as a relational and social being, who craves recognition by others and is shaped by prevailing discourse, allows us to appreciate the role of social norms in the subject's formation (Fotaki, 2016). The novelty of her approach is to stress the importance of affective attachments to these norms, including professional or institutional symbols and values. Various accounts describe the importance of socialisation processes by which new entrants are schooled in the norms and values of the professional community (Pratt, Rockmann and Kaufmann 2006) and given cues which inform emotional expression (Hafferty 1988; Smith and Kleinman 1989). Although these studies highlight the significance of emotion in professional/ client interactions, they pay less attention to ongoing relationships between professional and clients, which may take place over many months or years. Fotaki's (2014) work drawing on Butler's ideas to propose a relational model of interpersonal trust as an affective process developing over time between patient and doctor and allowing us to deal with dependency on the other in situations of vulnerability and distress that are common in health care encounters, is the only study we are aware of that addresses this issue. In other words, the temporal dimension and its impact on (relational) subjectivity have received little attention in the literature on professionals and their sense of self. Furthermore, in making sense of oneself we are influenced by our understanding of temporality. As Honkanen (2007: 4) writes in her explanation of temporality in Butlerian theory,

> Epistemologically speaking, now-time produces knowledge of presence, of things in the "here and now". Now-time makes phenomena present and "real" and is a key ingredient to the comprehension of history. Now-time also is vital for the subject's ontological constitution. The concept of nowtime enables us to comprehend ourselves as being part of temporal movement. … we become visible by placing ourselves in various temporal presents. We seem to "know" that history is for real but we also seem to be able to "experience" temporality. Hence, historicity also has its affective side. There is something about historicity that we can "feel" and "sense".

Butler's reframing of subjectivity in relational terms has important implications for the ways in which we consider understandings of temporal processes in organizational life. She conceptualises discourse in a way which goes beyond describing the conscious actions of speaking subjects. The process of recognition is central to the subject's sense of self, but identification with the other or the established social norms (known also as the symbolic big Other in Lacanian terminology – see Fotaki, 2010 for a detailed discussion) is never complete or merely mimetic but entails wish fulfilment operating at the level of fantasy. Identifying with a fantasy is conditioned and mediated by language which 'not only produces that fantasy but then describes that configuration within an uncritically accepted topographical discourse' (Butler 1990:333). Discourses are constituted within a context of unequal power relations and being out of step with the prevailing discourses concerning the past, present and future cannot be easily resolved by individuals. Instead this is likely to lead to alienation within the organization and potentially beyond it, resulting in self-doubt and loss of identity. Achieving a shared temporal narrative, from this perspective is important because the organizational actors' sense of self is shaped by the circulating discourses which characterize their environment. Furthermore, 'we must conceptualize temporal concepts as discourses – sites for thinking and resistance' Honkanen (2007: 4).

Fantasy, time and endurance

Temporal concepts are important in relationships with others (other individuals or objects), particularly when it comes to sustaining fantasy and related to this our sense of self. Living in the 'here and now' enables us to create attachments towards desired object-ideas, which are proximate but never in the present time and space. As Berlant puts it they are: 'the objects of desire who make you possible (by having some promising qualities, but also by not being there)' (Berlant, 2011:26). These objects help to sustain a fantasy and provide a coping mechanism in challenging circumstances such as the ambiguous contexts inhabited by the professionals in our study. At the same time, although attachment to an object is life-sustaining, the object is simultaneously a threat to individual flourishing. We turn to Berlant

to explain why this maybe the case:

> ‘But so many of the normative and singular objects made available for investing in the world are themselves threats to both the energy and the fantasy of ongoingness, namely, that people/collectivities face daily the cruelty not just of potentially relinquishing their objects or changing their lives, but of losing the binding that fantasy itself has allowed to what’s potentially there in the risky domains of the yet untested and unlived life’ (ibid. 48).

We draw on Berlant’s (2011) notion of fantasy which is particularly relevant for our purposes as it concerns its temporal dimensions and locates fantasy in the social context of everyday life and work. Berlant’s concern is with attrition of a fantasy and adjustment to the loss of this fantasy. She argues that for many people, the gulf between the fantasy of a fulfilled life and the lives we lead is so wide that we engage in ‘suspension of the self’ as a form of self-care. ‘Cruel Optimism attends to practices of self-interruption, self-suspension and self-abeyance that indicate people’s struggles to change, but not traumatically, the terms of value in which their life-making activity has been cast’ (2011:27). Individuals engage in practices (sex, spacing out, (over) eating) that provide a temporary relief (making life a less bad experience rather than making it better) but mostly do not abandon their attachment to a fantasy. This is why the object can never be experienced in the ‘here and now’ since its removal to another time is what makes its fantasy sustaining function possible.

Whilst Berlant is concerned with suspension of agency and its relationship with the fantasy of a good life, Lisa Baraitser, another researcher working with the concept of time from a psychoanalytic perspective, is concerned with how such suspended agency relates to suspended time. Central to this is the notion of maintenance, which involves durational activities that keep things going ‘objects, selves, systems, hopes, ideals, networks, communities, relationships and institutions’ (2015:21). Maintenance contains two temporal forms. One of these refers to keeping things on an even keel, ticking over with ‘one moment looking much like the next’ (2015:27). The second aspect involves keeping buoyant, underpinning or propping up which orients us to a future in contrast to the more conservative tendencies of maintenance practices. Noticing the characteristics of time inherent in maintenance matters to how we understand time (2015:42) and paying attention to this ‘stuck time’ (2015:42) of maintenance may help us to create different temporal arrangements that intervene in the dominant temporal imaginaries of our time (2015:42). Bringing the two together Baraitser describes a process of renewal through maintenance. When we engage in acts of maintenance we are keeping going our lives and those of others in our social worlds, as well as a relation with a temporal imaginary which is not ‘completely

circumscribed by a foreclosed future, a stuck present or a melancholic past' (2015:30). For Baraitser, maintenance involves repetitive acts stretching over time whilst enduring an ongoing state of little happening in terms of changes which bring us closer to a desired fantasy object. Yet rather than thinking about this in terms of a waiting zone 'maintenance time points us towards the time involved in maintaining connections with one another….it recognises that 'betterment' is not a time in the future, but the time we labour within now, in its repetitious, bleak and at times ugly forms. To grasp the time of maintenance is to take the time that doesn't slip through our fingers as 'our time', the time we have' (2015:43).

Baraitser describes endurance as a psychosocial practice 'involved in the complex and ambivalent processes of care' (2015: 29), with what we do today potentially having an impact beyond our own lifetimes. She suggests, however, that we may be wrong to view the present in terms of its instrumental relationship to some future goal or conclusion, although this is a common way of viewing the maintenance practices in which we engage. This raises questions about the ways in which clinicians (and indeed patients) endure in a context where both groups are interacting over a period of many years in a context where clarity about what constitutes the patient's best interests is absent. We explore this further after describing our study context and methods.

The study context

Healthcare settings provide fertile grounds for examining emotional responses amongst professionals (e.g. Bott 1976; Menzies 1960; Roberts 1994). The field of forensic psychiatric provision in secure hospitals in England is similar, to some extent, to mainstream healthcare settings, but since it involves provision of care for mentally disordered offenders, it differs in important respects. Hospital residents are patients and at the same time offenders. On the one hand, the aim is to rehabilitate and 'cure' patients in a caring environment. On the other hand, patients are detained against their will in a regime which applies pressure to comply with therapeutic interventions. Practice is governed by a detailed and mandatory framework. Historically, the desirability of containing and segregating 'mad' individuals (Foucault, 2001; Prior 1988) from the rest of society meant that 'asylums' were set in large grounds, removed from major centres of population. Two of the current three English high secure hospitals are housed in asylums dating from the late nineteenth and early twentieth century.

In England and beyond, growing unease with the asylum model for the mentally ill in the 1960s and 1970s led to a policy of deinstitutionalisation (Killaspy 2006), which involved closure of long stay psychiatric hospitals and provision of services in the community. This did not apply to forensic psychiatric hospitals, but in 2000 a commitment was made to expand medium secure provision and a formal policy, the 'Accelerated Discharge Programme'

(ADP), resulted in around 400 patients being discharged to medium secure facilities (Department of Health 2000). The aim was to ensure patients were in the least restrictive setting possible, but also to stimulate treatment and avoid benign neglect. This can be seen as an attempt to disrupt the established patterns of staff behaviour in long stay institutions, which were regarded to promote lack of care and complacency. At the same time, there is an emphasis on constraint combined with high levels of securityFrom the perspective of the public, the patients, many of whom are murderers, paedophiles and rapists, are dangerous and evil and there is some evidence that these attitudes resonate with some members of staff (Pilgrim 2007). Whilst it makes sense to ensure that appropriate levels of security are maintained, the hospitals in England tend to have more restrictive regimes than their counterparts in other countries (Salize and Dressing 2005).

In the context of deinstitutionalisation, a 'recovery' (Shepherd et al. 2008) based approach to mental illness has gained increasing traction with patients and professionals. This, in contrast to the traditional paternalistic medical models of treatment, aims to empower patients. At the same time since patients may lack capacity, it may be necessary to coerce them into complying with treatment regimes and practices. This is because patients are viewed as a risk to themselves and others and need to be contained, with psychiatrists charged with acting in the patient's best interest. The professional body, the Royal College of Psychiatrists (RCP) has stated that the only reason for psychiatric intervention is for patient health benefit, with any related public protection function being secondary to this (Coid & Maden 2003).

Changes over time have led to an approach which emphasises recovery, as opposed to merely incarceration and containment, therefore. Successive governments have been preoccupied for many years with the question of how to lawfully control behaviours amongst the mentally disordered, which pose a threat to the social order, especially where such disorders are not curable. Although regulatory changes such as the ADP, supported this shift, more recently legislation has implicitly challenged this. The 2007 Mental Health Act abolished the 'treatability test', which required that detention in hospital of people deemed to be a risk to themselves or others was only legal if their condition could be treated. Now it merely obliges hospitals to ensure that 'appropriate treatment' is available, with no requirement for the treatment to be effective. In the Netherlands, forensic patients for whom effective treatment does not exist and are therefore deemed to require lifelong care reside in a facility located many miles away from the secure hospitals (Uslu and Mok 2009). They are not subject to medically intensive psychiatric treatment or psychological interventions intended to reduce their risk but are likely to enjoy a superior quality of life to those in secure hospital settings. No such facilities exist in the UK.

As part of the regulatory framework forensic hospitals are subject to inspection by the Care Quality Commission (CQC) which is the independent regulator of health and adult social care in England. Whilst doctors are expected to act in patients' interests, there are other mechanisms in the system to protect these interests. These include legal representatives and third party payers ('commissioners') who award and monitor contracts for the patient's care. Most of the commissioning staff have a background of working in forensic hospital services but they are not doctors and cannot initiate service changes. Doctors are relatively powerful actors in the organisational context and field more generally and much of what is commissioned is informed by an advisory group comprised of forensic psychiatrists.

In summary, the public protection function doctors are required to exercise, in a context where patients may not necessarily perceive themselves as being ill, sits uneasily with the emphasis on recovery (Shepherd et al. 2008) and its related implications for patient empowerment. Normative prescriptions relating to the need to ensure recovery and rehabilitation are not well aligned with the needs of patients who may never leave secure settings and the wishes of the State to detain these people indefinitely. Deciding what constitutes the best interests of the patient, taking into account the interests of the public, victims and their families is no easy matter therefore.

In the literature on professionals and interests, patients (or clients more generally) receive far less attention than employees. Where they are discussed, they are often depicted as relatively passive recipients of the (adverse) consequences of defensive behaviours of staff members (e.g. Menzies 1960). This is perhaps understandable given the aims of research which frequently focus on organisational issues that are assumed to concern staff rather than patients and the fact that the former are much more powerful than the latter. However, for our study we thought that client attitudes and behaviours in addition to those of doctors, would be important in the context of relational subjectivities and discourses of recovery which imply empowered patients as we describe in the following section.

Methods

We interviewed 30 doctors, (representing 12% of the consultant forensic psychiatrists workforce nationally), from 27 different care facilities and four managers ('commissioners') who act as third party payers for the care provided. We also conducted 40 interviews with patients in 8 facilities. We recruited patients by asking clinicians in these selected facilities to identify patients who had been in care for many years and were unlikely to be released within the next 2 years for us to approach. We used a mixture of purposive and snowball sampling to recruit staff participants across a broad geographical area. Initially we contacted psychiatrists who were members of an advisory group informing national service planning

decisions because we wanted to speak to individuals who might have a broad, as well as local knowledge.

With the permission of interviewees, all interviews were digitally recorded and transcribed verbatim. We also spent a day in each of three 'long stay' secure forensic facilities where we visited wards, met and talked with staff and patients. For two of these visits we made notes as soon as we left the facility as we were not allowed to take in recording equipment. At the third site, we held a focus group with staff (2 nurses, 2 psychiatrists and 1 psychologist) and digitally recorded this. We also held two focus groups at a forensic psychiatry conference each comprising 3 psychiatrists and 2 members of the research team. We used focus groups in one hospital to explore nurses' views. The intention was also to allow nurses from one organisation to discuss their experiences with each other, in order to use dialogue as a way of prompting discussion and debate. Eleven participants were recruited and divided into three focus groups (with five, four and two participants). The uneven numbers across the groups was due to scheduling issues and last minute cancellation due to other work demands. Data were collected through in-depth qualitative interviews and analyzed using an abductive approach, moving back and forth between theory and data (Alvesson and Sköldberg 2009). We chose content analysis carried out through an adaptation of Gioia et al.'s (2012) methodology that supported the poststructuralist and psychosocial approach adopted for the study.

For the analysis, interview, focus group and site visit notes and transcripts were entered as text files in NVivo. These were coded to identify themes which formed our first-order codes (Gioia et al. 2012). We then reread transcripts, coding for any additional themes. We constantly compared coded documents and discussed possible conceptual patterns. The second step of the analysis involved collapsing codes into higher-level nodes. These formed our first order categories. Then we looked for links among first-order categories so that we could collapse these into theoretically distinct clusters, or second-order themes. As part of this process we identified various ways in which time was perceived by various organisational actors (see table one). The fourth step of the analysis involved organizing our second-order themes into an overarching process model that underpinned our theorising where we followed an iterative approach comprising going back and forth to the data and our core concepts derived from psychoanalytical theories discussed above involving ideas such as recognition by the other, fantasy of good life, and suspended time. Additional supporting evidence for our overarching understanding is presented in Figure 1.

Findings

Everyday work as future oriented

The accounts of many clinicians suggested that being in step with the discourse of recovery was important in helping to maintain their sense of self. Temporal resources helped to preserve a view of activities as meaningful and serving patient and public interest. The present was linked to a bright future with activities in the 'here and now' being meaningful insofar as they were aimed at achieving recovery in the future. Maintaining the fantasy of recovery appeared to be very important to professionals, despite the fact that many patients would never leave secure settings. In staff and patient accounts the future was a place filled with potential and in particular the possibility and assumption that patients would be discharged one day. Yet this future, by definition, never arrives and it is possible therefore to avoid the painful reality of patients not moving on through the system. In Berlant's (2011) theorisation, the future is in proximity to, but not part of, the here and now of everyday life in the hospital. Importantly, its promise is viewed as attainable at some point in time. The present was depicted not merely as a stage of marking time or waiting for something beyond one's control (cf Frosh 2015). Instead, for clinicians, it was important to engage in active treatment of patients and continue this indefinitely. This resonates with Baraitser's description of maintenance comprising repetitive acts stretching over time whilst enduring an ongoing state of little happening in terms of real changes and this was necessary for bringing clinicians closer to a desired fantasy object (of recovery). Occasionally doctors would acknowledge that patients would not be discharged but despite these fleeting glimpses (describing going through the motions, paying lip service to reviewing patients who will never move on) of a painful reality, generally most doctors insisted that patient treatment was part of a journey towards a future recovery.

> *You know everything that we seemed to have gained in the last few years about recovery and about participation and so on has been about motivating people to change because of the prospects of something better than custody and being locked up and if you were to take a unit where you had deprived anyone of those opportunities it would be very difficult to keep positive relationships and to keep people motivated.ID2*

The emphasis on the present as meaningful and the future as bright contrasted with the view of the past as deficient and dysfunctional. As the quote above demonstrates, maintaining attachments to the desired object of recovery was important to maintain 'positive relationships' and 'motivation' even though discharge for many patients will not be achieved. The current treatment in the idealised 'recovery' oriented organisation was contrasted with the bad old days of the asylums where patients were not subject to active psychiatric and psychological interventions.

asylums were places where you could live a life away from society in a very contained bubble and not be put under any pressure whatsoever to engage in treatment… I don't want us to go back to that way of being. ID10

The splitting of care approaches into wholly good and wholly bad aspects appeared to enable staff to relieve anxiety associated with their everyday work without resolving the original source of anxiety (Fotaki, 2010). In contrast to other psychodynamically informed studies in mental health settings (Fotaki and Hyde 2015; Greenberg 2016; Hyde and Davies 2003; Willshire 1999), staff did not blame insufficient time or inadequate resources for the lack of progress. This would be difficult to do since the organisational context is relatively relaxed given the nature of these 'long stay' patients and the fact that the same groups of staff are involved in their care over many years. There was instead a tendency to engage in blaming patients for the fact that recovery had not yet been achieved. Denial was commonplace with staff avoiding the issue that treatments were not effective.

The majority of ….patients we've got have got a severe and enduring mental illness with gross loss of insight and treatment responsiveness. … We've got one who is a rip-roaring psychopath …he's going to be in high secure for twenty plus years and really difficult – I wouldn't want him managed in any other environment …..he's had loads of treatment but he's still risky ID11

Doctors, nurses and psychologists in talking about the need to maintain treatment for patients engaged in what might be interpreted as a splitting off of the undesirable realities of the situation. This meant that caring for patients, for whom effective treatments were not available, was (apart from some exceptions which we discuss later) generally not discussed explicitly. Instead the context was described in terms of patients being 'treatment resistant' and/or lacking insight into their condition (See Table 1) . This avoided painful emotions that might otherwise be experienced by 'failing' doctors and/or deficiencies in treatment. It also avoided explicit consideration of whether it was in the patient's interest for doctors to encourage them to aim for recovery when this was an unachievable goal.

Clinicians appeared reconciled to some extent with letting time take its course and being patient as various treatments were offered. In many cases patients underwent various programmes of treatments several times with no effect. However, clinicians also sought evidence that patients were improving in some way and/or engaging with treatment as this was important in helping to maintain clinicians' attachment to recovery which would be achieved at some point in the future. As part of this process of maintaining their sense of self they were emotionally dependent on patients exhibiting behaviours that clinicians could interpret as signs of improvement, however slight and ephemeral. Having some small sign

that patients were responding was comforting for staff and interactions with patients might be seen as part of maintenance time which is important in itself rather than being linked to a 'foreclosed future' (Baraitser 2015) of recovery.

In addition to blaming patients and remaining optimistic about the achievement of the desired object of recovery materialising at some point in time, clinicians also engaged in outright denial by refuting any suggestion that there would be some patients who would never leave. The idea that patients should not receive active treatment was resisted with this described as 'warehousing'. In some cases, it was a matter of waiting and hoping that a new drug or treatment would be developed at a point in the future, but this waiting time was future oriented as opposed to being of value in and of itself.

> *[A] unit shouldn't abandon all therapeutic hope. I mean it might be that you have to just say it looks like 'John' is going to be here with us for a very long time … anyone who's been around a for a while, you do see people change and unexpectedly…You can never give up. ID5*

Patients reported varying degrees of participation in and compliance with treatment regimes, largely avoiding confronting the reality of incarceration for the rest of their lives. Complying, as opposed to appearing to comply, with treatment appeared to be helpful to patients in sustaining a fantasy and shielding them from pain. They were dependent on clinicians to provide them with praise and reassurance and not just merely clinical expertise. In Butler's terminology patients sought recognition from them. In terms of temporal perspectives, they often described the 'old days' in terms of former deficient selves which were transforming over time. However, since having 'insight' and taking responsibility for one's crimes was often a requirement for treatment there are incentives to provide accounts which fit with those requirements. For patients, in the context of a painful reality, many acknowledged their illness and engaged in idealisation, hoping for 'recovery' and discharge in the future, at times splitting staff into wholly good and bad groups.

> *He just offered me no hope …. the judge turned round and said…'I'm gonna actually, er, advise the Home Office that you never be released'… It's getting brighter now. Yeah. Because of all the changes in nurses' attitude and recovery… In a proactive way, like moving you forward, not just keeping you detained IDA3(P[1])*

> *you get psychology, you get social skills… CBT, done that, just doing that one now… It's brilliant, all the courses I've done are brilliant. [When I get out] Working outside for the RSPCA looking after animals… volunteering and my own flat IDA1(P)*

[1] P denotes patients. Other quotes are from staff members.

Additionally, they described working through treatments over time as they moved towards the desired object of recovery. The emotional magnitude of maintaining the fantasy of recovery was apparent during the study when we experienced the effects of exposing patients to the potentially painful suggestion that they may never move on). When patient interviewees were asked to give views about a Netherlands-style service for patients who will never leave, this caused them such anxiety in several cases that the question was dropped from the interview schedule.

That's wrong – because you've got to test people. You've got to give them an opportunity…. I think that is a disgrace ...Just keep people for the rest of their lives and don't worry about it. That means you've washed your hands. if that's what they're going to try to do here I'll work very hard in the background to try and make sure they don't get away with it IDK3(P)

The present as unproductive

Perhaps not surprisingly, many patients challenged the existing arrangements. Rather than accepting that they were mentally disordered and admitting their past criminal behaviour, they engaged in denial, refusing to comply with treatment, rejecting their diagnosis and blaming others for their incarceration. They remained attached to the desired object of discharge, although not recovery since they did not see themselves as ill. For patients who lack what the psychiatrists called 'insight' (i.e. acceptance of their problems and guilt and the importance of engaging with treatment) a more 'rational' approach would be to feign compliance, and some admitted to doing this. Instead for some, their response can be seen, in part at least, as a fantasy which helps shield them from accepting a painful reality of taking responsibility for often violent criminal behaviour as well as rejecting the label of 'mentally disordered'. This acts as a coping device and a fantasy of discharge enables them to maintain hope, although they experience daily life as boring and marking time, as opposed to progressing to a more fulfilling future via participation in treatment.

I'd finished everything and just waiting for this and waiting for that. This is where time just gets run out…. But on the tests that I've done, here when I first came here, I've dropped right down. Even the psychopathy band's dropped down…. I really get to the point where, you know, the only people that seem to see a problem are the professionals… we should be going back into the bloody community. Damn it IDK2(P)

Even amongst more compliant patients for whom endurance is not about remaining the same, but instead concerns the conditions necessary for something new to occur, most accounts described a monotonous existence punctuated by mealtimes and occasional activities. The feeling was of a never-ending and extending waiting in the present. Patients described engaging in practices which provided relief from their daily lives such as (over) eating and taking drugs. These activities might be seen as 'releasing the subject into self-suspension' (Berlant 2011; 116), providing small pleasures in the present in a way that is not future oriented.

> *Very structured, very boring. If they made activities all the time everyone would go all hyper and we'd all get excited and end up fighting each other.…. If we played bingo every night right? Everyone would get excited, fighting over bingo prizes. This is the best it gets, it's not going to get any better. It's no good thinking about how you are going to get out all the time… I could live the rest of my life. See this is a waiting game isn't it.. You wait around all the time for things. .. you wait for your dinner, you wait for things to be served… the whole waiting game here is that it will happen but it happens at set times ..Everyone can sell drugs. They can sell their medication…. It happens all over the hospital…. Once you used to get caught with it in your system they would suspend the whole entire ward. They would go around and search everyone. Now they find it, they just leave it. … Because it was a waste of time. They used to a massive search for a little piece of weed. IDA2(P)*

It was not just patients who were critical of the existing regime. Older doctors in particular, highlighted deficiencies describing treatments as being of 'feeble efficacy' (ID22). These doctors were much more willing to challenge current ways of working and to advocate cessation of treatment, where this treatment was not effective. They did not resort to blaming patients, but instead criticised the approach of younger doctors who appeared to be attached to a fantasy involving recovery at some point in the future. Furthermore, the leisurely pace of life on the wards, which provided little in the way of distraction for patients, meant that over time it was difficult for clinicians to avoid the clash between reality and the discourse of recovery. This had to be avoided at any cost for fantasy of recovery to be maintained since blaming lack of time for hampering recovery was not an option. However, rather than bolster a discourse of recovery and discharge as objectives for all patients, these clinicians articulated opposition to it.

> *some people can still find some work and fulfilment in their life, even if they're detained for life in custody ... You never, ever give up hope …for some people for whatever reason …they will not get out … That's the reality … and it would be really good if they*

didn't do just law degrees because that's what they tend to do so they can have very interesting tribunals. But how else do you fulfil yourself? It should be possibleID16

While commissioners do not interact directly with patients, they enable funding to be provided for their care. As managers employed by third party organisations, they are less likely to be emotionally invested in the organisational ideal of a particular hospital. They suggested that rather than services leading to recovery, in many cases patients would not recover. A more explicit acknowledgement of this would create an impetus for alternative models of care in contrast to the existing services, which placed unduly harsh restrictions on patients diminishing their quality of life unnecessarily. They were supportive of refocusing on improving patients' lives in the present rather than holding out for recovery in the future. Commissioners are not psychiatrists however and lack the power to initiate changes to services to introduce new models of care although they did express views about how such services might be organised.

there is a group of people who can sit in secure services and I would have to say predominantly it's people who have sex offending as their background... What they need is the relational security of staff who are working with them and around them who know of the risk that they represent to others... What they would need is a structured accommodation...and 24hr supervision… And their quality of life would increase greatly. ID33

Maintenance time as productive

As illustrated above, in common with commissioners, not all clinicians were attached to a fantasy involving recovery at some point in the future. For older doctors in particular, the past, as opposed to the future, was a time when things were not as bad as painted by younger clinicians. These doctors referred to the loss of important aspects of the old organisational context which if reinstated could improve patients' lives in the 'here and now'. For example, the fact that former asylums were set in large grounds, which in some cases included small farms and pasture areas, meant that patients could be happy in the present, without having to resort to a fantasy of recovery to be achieved at some point in the future. Rather than being attached to the goal of recovery, these professionals spoke openly about focusing on maintaining a good quality of life for patients as opposed to engaging in active treatment. This implied a shift from cure to care and they also suggested that some of the old methods used for staff training should be revived. These could help staff deal with the reality and the negative emotions aroused by caring for patients who would not move on through the system.

and some people say it's a bit old-fashioned, people going to work on a farm or having day trips to the beach or something like that to improve their life, you don't do that here anymore. That was what you did in these big total institutions that we now say they shouldn't exist anymore. But the reality is they do exist, just without the quality of life! (laughs) ID23

These older clinicians, with less time ahead of them did not have to maintain the fantasy of recovery for many years, since they were much closer to retirement than their younger counterparts. Their views of the old asylum system as not entirely bad might also reflect the prevailing wisdom in the period when they trained. Their responses might be read as a more measured approach with an absence of the sorts of denial and blaming of patients exhibited in the accounts of younger clinicians. However, their criticism of the current strategy involves some blaming of clinicians and the clinical practices which support it. Furthermore, these upbeat views of the asylum contrast with much of the literature on the topic. The problems of these 'total institutions' (Goffman 1961) were highlighted in inquiries in the 1980s which found that the emphasis was on producing places of incarceration with staff engaged in excessive brutality, routine seclusion of newly admitted patients, 'inflexible and over structured regimes…. and too little scope for the development by patients of self-awareness and self-control' (Martin 1984: 55). The accounts of older doctors suggest a rose tinted perspective, conveying at least in part an emotional attachment which may not be based entirely on an objective appraisal of the facts. Ambivalence about their ability to uphold the professional norms to which doctors are attached (i.e. to enable patients to recover), cause them to redefine their goals. This in turn leads to their uneasiness about this scaling down of their expectations, resulting in idealization of previously discredited treatments.

Amongst patients who did engage in treatment, some were ambivalent about moving on. Whilst hope for the future appeared to motivate them, at times, this was accompanied by fear of failure and not being able to cope. In some cases this led patients to sabotage plans for moving them to a different facility with a lower level of security. Fear also led some patients to avoid hoping for and expecting a positive outlook, in case they had their hopes dashed. All patients have a lot of time on their hands, which makes one patient's reason for missing tribunals ('every time…it falls on an awkward day when I'm busy'), at which their potential discharge is discussed sound not entirely truthful. A small number of patients suggested that they would prefer life in a Netherlands style facility if it was deemed that they needed to remain in secure care.

I guess if it means that my risk will never be manageable to the point where I can safely be in the community, then the best quality of life that I can expect or hope for… people

are always saying while I'm here that I'm still a risk. My risk hasn't changed, that I still need to be detained, that I'm still unwell, I'm still disordered, that I still need further treatment… it's interminable, it's protracted and complicated… If somebody said it's either stay in [this hospital] until you die or go to a place where you have more freedom, more autonomy… that would be preferable…[where]. .. people seemed to have a sense of belonging and purpose. Which is a big difference than being here when the most purpose I have is a competition to have a game of pool to see if I beat somebody else. R4 (P)

For some patients they were happy in their environment and took pleasure in their day to day relationships and interactions. Their accounts resonate with those of older doctors in terms of the importance of appreciating the time we have now. The views are consistent with Baraitser's (2015) concept of 'maintenance time', which despite being an ongoing state of little happening in terms of changes which bring us closer to a desired fantasy object, is nevertheless a source of betterment. Betterment is defined in terms of the relationships and activities that sustain us in the here and now as opposed to a future unachievable goal.

As we describe above, the passage of time over many years means that patients and clinicians are confronted on a daily basis with reality which is patients not moving on. The absence of frenetic activity and the fact that many patients are detained for most of their adult life makes it difficult to blame lack of time for failure to cure. Despite the insistence of professionals that 'warehousing' was unacceptable, these same professionals were involved in initiating and implementing changes to stop treating these patients who cannot be cured. They described a gradual realisation that having older, 'long stay', patients on the same ward as other patients who moved through the system could demoralise the former. Furthermore, often as staff and patients outlined, these older patients were a target for bullying and mixing younger violent and acutely ill patients with them created problems. Such factors were reported as motivating staff to change services to make them more 'homely' in recognition of the fact that these patients would not be moving on. Clinicians described how they were establishing new services to create a separate area for patients who would not be going back into the community. They suggested that it was important to focus on quality of life, which was in part a euphemism for cessation of treatment. Yet at the same time these same clinicians continued to insist that these patients would not be staying for the rest of their lives and clinicians held out hope for their recovery.

The names given to these facilities included 'enhanced recovery' and 'slow stream rehabilitation' wards and clinicians deliberately avoided suggesting that these were for 'long

stay' patients despite the fact that 'long stay' is itself a euphemism to disguise a potentially painful reality.

> *A home for life, this is how patients were moved in…..what I don't want this to turn into is warehousing. That would I think be soul-destroying for everyone involved…. it's doing things differently that you know, it's some hope, it's some chance, it's some slightly different angle that you're going in and that just might be the gateway into somebody actually managing to move on. FG 3. ID 3.1*

At our site visits we found that in these new services, changes had been made which included in many cases cessation of treatment. However, they were not remotely homely and patients' quality of life left a lot to be desired, especially compared with the Dutch facilities (Uslu and Mok 2009). Sexual activity was not permitted although there is no national policy preventing this and in the absence of such a policy staff are free to apply their own judgment. Staff attitudes in the settings we visited contrasted with those in other countries such as Germany and the Netherlands where sexual activity between patients or with an outside partner is permitted (Majid 2015). Doctors explained the need to protect vulnerable patients and highlighted the fact that many patients were sexual offenders, implying that they saw engaging in a sexual relationship as an obstacle to recovery (Brown et al. 2014). These responses may reflect the broader social and cultural context in which forensic units are situated, with less liberal views regarding sexual relationships in the UK than the Netherlands for example (Brown et al. 2014). They may also reflect deep seated anxieties relating to madness fuelling deep suspicion of any activity that might be viewed as stimulating or enlivening. The result is 'techniques for deadening all contact and stimuli, especially emotional ones… in spite of decades of conscious attempts to improve the quality of life for patients by providing a lively and stimulating environment. The unbreached resistance to all such efforts …is telling evidence of the power of the unconscious' (Hinshelwood 1987: 210).

Furthermore, explicit acknowledgment of their failure as doctors to facilitate 'recovery' threatens to expose clinicians and many patients to pain. For some patients, especially those who do not hope for release, a Netherlands-style alternative might be preferable to the status quo. Similarly, the pain caused by acknowledging failure (or abandoning hope and 'warehousing' patients) means that doctors articulate what is happening in ways that both acknowledge and deny simultaneously the true nature of their new facilities. These denials reflected in their incoherent accounts and bolstered by their insistence on the need to maintain a focus on recovery in the future helps to alleviate pain. They also prevent a more

explicit discussion of radical change to services and to the temporal imaginary, which sees the present in terms of the future, as opposed to worthwhile in and of itself.

Discussion

In this article, we have considered the accounts and actions of professionals working in contexts of ambiguity to explore how they maintain their sense of self in their everyday work as they have to reconcile public interest and uphold the norms of their profession to benefit their patients in conditions of ambiguity and uncertainty. We are particularly focused on the unconscious emotional dynamics which explain the phenomena we describe. We also considered patient perspectives since, in the context of subjectivity as a relational process, these are important in understanding the ways in which professionals maintain their sense of self in the ambiguous setting we describe.

Our findings offer two substantive contributions. First, we contribute to the study of professions by advancing understanding of the relationship between professions and interests, illuminating the nature and dynamics of the problems faced by professionals in ambiguous contexts. We contend that when faced with alternative conceptions of what constitutes the patient's best interest, clinicians prioritise one of these over the other. This is not necessarily easily accomplished. Indeed, over time, it may be that professionals feel obliged to revisit and revise their choices as part of the process of maintaining their sense of self. The relationship between self-interest and patient interests is a complex one. Although the doctor-patient relationship takes place within a context of unequal power relations, the conflicts doctors' accounts illustrate are not directly concerned with struggles involving status and wealth. Instead, clinicians feel torn between acknowledging that patients will not 'recover' and continuing to participate in and perpetuate a recovery discourse, as they are faithful to their professional norms. This attachment to norms is affective: it 'precedes and enables the constitution of subjectivity' (Butler 1993: 225). Professionals care about patients and want to do their best for them, but the ambiguity surrounding patient interests makes it difficult for clinicians to maintain their sense of self in everyday work. In addition to the local organisational actors (patients, clinicians and payers) there are also other important influences on clinicians. Many members of the public perceive these patients as mad and dangerous (Pilgrim 2007) and pressure from government departments to contain patients co-exists with pressure from elsewhere in government and society to enable recovery (Shepherd et al. 2008).

Indirectly, however, clinicians' actions and accounts can be seen as serving professional interests insofar as failing to openly acknowledge the limitations of professionals helps to maintain the public's trust in the profession. The State's emphasis on active treatment and

recovery and a move away from institutionalisation helped to fuel the rise of forensic psychiatry as a profession. It has grown from '2 professors and 18 consultants confined to working in a few grim special hospitals' (Turner and Salter 2008) in 1970 to around 260 consultant doctors according to the latest census (Centre for Workforce Intelligence 2010). This is based in large part on trusting forensic psychiatrists to deliver patient and public interest and any acknowledgement of the limitations of professionals, risks threatening their status, wealth and power. However, clinicians' actions should not be interpreted as a cynical attempt to maintain their privileged position. Instead, we show the importance of conceptualising 'interest' in a way which incorporates emotional factors, going beyond the tendency in the literature to focus on conscious and rational motivations of professionals. In doing so we drew on the psychoanalytic concept of subjectivity as constituted through recognition by others and affective attachment to norms and symbolic values (Butler, 1993). We also introduced the notion of fantasy, which has proved valuable in other areas of organization studies (Ekman, 2012, Fotaki, 2010; Vidaillet, 2007), to provide a fruitful avenue for exploring how affective attachments to the desired future influence people's actions. Berlant's (2011) notion of fantasy was particularly relevant for our purposes as it concerns its temporal dimensions and locates fantasy in the social context of everyday life and work. The ideas of Baraitser who recognises the importance of locating temporality in the context of power are also important to understand the concept of suspended time and individuals'' endurance. In our study, clinicians might be seen to be in a position of power relative to patients. For both patients and staff the concept of endurance might involve having to stay with something until it reaches a conclusion. At the same time the notion of endurance implies that this conclusion is not within their control, at least not in the 'here and now' of the present. 'Waiting is a strange business; it is the thing before, yet also a thing in itself; it is out of time, frustrating because we might want to get on with something, part of the process of achieving what we want, but also abstract and empty.… Endurance is required when someone else is calling the shots, or when something is acting through us that compels us to stay on and keep trying; or when we want something so badly that we have to wait and wait until the opportunity comes to get it' (Frosh 2015: 171).

This links to our second contribution which speaks to the literature on professions and emotions providing a more nuanced description which is not focused on episodic emotional responses triggered by specific incidents (cf Wright et al. 2017), to demonstrate the importance of emotions as an ever-present feature of professional behaviour and identity. The ambiguous context creates, in many cases, emotional discomfort for professionals and engaging in prevailing discourses, even though their actions run contrary to these, provides protection from exposure to painful emotions. Patient and the State's expectations, as well

as the desire to maintain one's sense of self create huge pressures to maintain the fantasy of recovery. The broad social desire for organizations to neatly address large and intractable problems (Fotaki and Hyde 2015; Fotaki, 2010) has implications for the emotional wellbeing of professionals who work in them. Patients hope for recovery and/or discharge. Clinicians cannot explicitly articulate and implement an alternative strategy and even if they could, doing so would expose them to painful emotions. The emotions emerge from and are constituted through their relations. The ways in which modification to the strategy is undertaken therefore suggest more than a process of 'rational' professionals wanting to maintain power. This can be understood as an affective process connecting organizational, systemic and individual levels. For clinicians, rather than neat explanations or conscious rhetorical strategies, their accounts can be read as ambiguous, contradictory and apparently irrational. These accounts make sense when we consider previous work on social defences (Menzies 1960; Fotaki and Hyde 2015).

Our data illustrate how maintaining a policy of 'recovery' as an idealized 'good object' requires a psychological splitting off of any evidence of failure. Splitting and shifting the blame for any potential failures away from the self, are used to maintain the fantasy that unrealistic organizational objectives can be achieved. Blaming distorts reality and is a substitute for meaningful action to resolve problems. Blame is also counterproductive, as it is not about learning from experience but simply provides temporary relief from undesirable and overpowering feelings of failure. What our study adds is an understanding of the ways in which temporal resources are mobilised in the process of self-preservation.

A perception of time as only meaningful insofar as it will lead to a productive outcome in the future enables staff and patients to endure by focusing on the future. Talking about the desired object of recovery enables them to split off their story about this desired object from their emotional practices and behaviours in the present which are linked to having this object in their lives. This 'rhetorical animation' (Berlant 2011: 26) of the object enables optimism about it and its location in another temporal space is essential to avoid confronting a painful reality, but this object is also disabling. It prevents change and emotional development which might help individuals experience a more meaningful existence in the here and now.

Nevertheless, a focus on the here and now as meaningful in relation to a 'recovery' future is not enough to keep the uncomfortable reality at bay and over time, clinicians begin to initiate changes which involve a deviation from their everyday work. These changes are justified on the basis that this will result in an improved quality of life for patients and the creation of separate wards to bring 'long stay' patients together may reduce bullying and create a calmer environment. Such an environment might encourage a modification of the temporal

imaginary so that patients are not merely marking time and waiting for a desired outcome in the future. Yet these wards do nothing to create a more stimulating environment for patients. This is understandable given deep seated staff anxieties relating to madness which fuel deep suspicion of any activity that might be viewed as stimulating or enlivening (Hinshelwood 1987). At a conscious level, there may be a desire for creating stimulating environments, but the unconscious motivations of staff result in emotional contact and stimuli being constrained despite the declared intent. Our data suggest that it is not just the fear of madness which accounts for this apparently paradoxical behaviour. It is also linked to sustaining a fantasy, which is essential to maintaining one's sense of self as a professional. Activity to improve quality of life for patients, on the basis that they will not be leaving, means a threat to subjectivity and for many clinicians and patients explicitly abandoning this fantasy entails emotional trauma (Carr 1999) which they wish (at an unconscious level) to avoid. Older doctors are less inclined to defend the status quo and are supportive of alternative models of care which would focus on achieving meaningful experience in the present, rather than the future. Temporal concepts are 'discourses – sites for thinking and resistance' Honkanen (2007: 4) and these older doctors articulate an alternative discourse of the past, present and possible futures. However, they also engage in blaming and denial and are not immune to the unconscious affective processes we describe.

Our findings also highlight the role of power and in particular similarities and differences between the more and relatively less powerful actors (professionals and patients respectively) in relation to the ways in which they respond to failing strategies. These two groups are emotionally interdependent, with both reliant on each other to display appropriate behaviours to help reinforce the fantasy of a productive outcome at a point in the future. Beyond this, however, whilst patients' vocal non-compliance can present an explicit rejection of clinicians' views, this does not undermine the fantasy. On the contrary it is the failure to progress of apparently meek and compliant patients that creates more of a challenge to the discourse of recovery and the everyday work which supports it. This reflects the underlying affective processes which mean that patients are able indirectly to exercise power over the more powerful clinicians who are responsible for their care. At the same time, there are clear limits to this power in a context where only clinicians are able to make decisions about service provision and implement service changes. Whilst patients prefer these newer wards, many describe monotonous routines which they endure by engaging in defensive practices including avoiding hoping for discharge and stimulation, since having hopes dashed is painful. Some patients do suggest that they are happy in the here and now and/or are fearful of leaving which might imply a view of maintenance time as productive (Baraitser 2015). However, many patients engage in activity such as (over) eating and drug taking. These are

not necessarily processes of conscious active resistance to the hospital regime. Instead they can be read as an 'episodic intermission from personality, the burden of whose reproduction is part of the drag of practical sovereignty, of the obligation to be reliable…not being purposive but inhabiting agency differently in small vacations from the will itself, which is so often spent from the pressures of coordinating one's pacing with the [hospital] day' (Berlant 2011: 116). Many patients are obese, though calls for education on healthy eating (Forsyth et al. 2012) misunderstand the problem by failing to acknowledge emotional factors in unhealthy behaviours. Such practices of self-suspension are, in part, a mini-break from obligations to behave in certain ways, to work towards recovery in the future. They provide a relief, but not a repair and importantly they are often 'consciously and unconsciously not toward imagining the long haul' (Berlant 2011: 117).

Our study also illustrates the importance of time as a tangible or 'objective' resource and temporalities as implicated in emotional responses to ambiguity. Contrary to prevailing assumptions about the links between time pressures and stress (Deary et al. 1996; Pritchard 1992), we suggest that having a less time-pressured working environment can increase, rather than reduce, the threat of painful emotions in organisational contexts. Claiming a shortage of time can help defend against what would otherwise be painful emotions associated with choosing between alternative conceptions of patient and/or public interest. In contexts where lack of time cannot be used to justify deficient professional behaviours or performance, it becomes increasingly difficult to deny painful realities. In some cases, deficiencies at the organisational level have been blamed on myopia which encourages individuals to overlook distant times (Levinthal and March 1993). However, when we consider the role of unconscious emotional dynamics, our data illustrate that a focus on the future can help to sustain a commitment to professional behaviours which may not serve patient and/or public interests.

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Figure 1 Data Structure

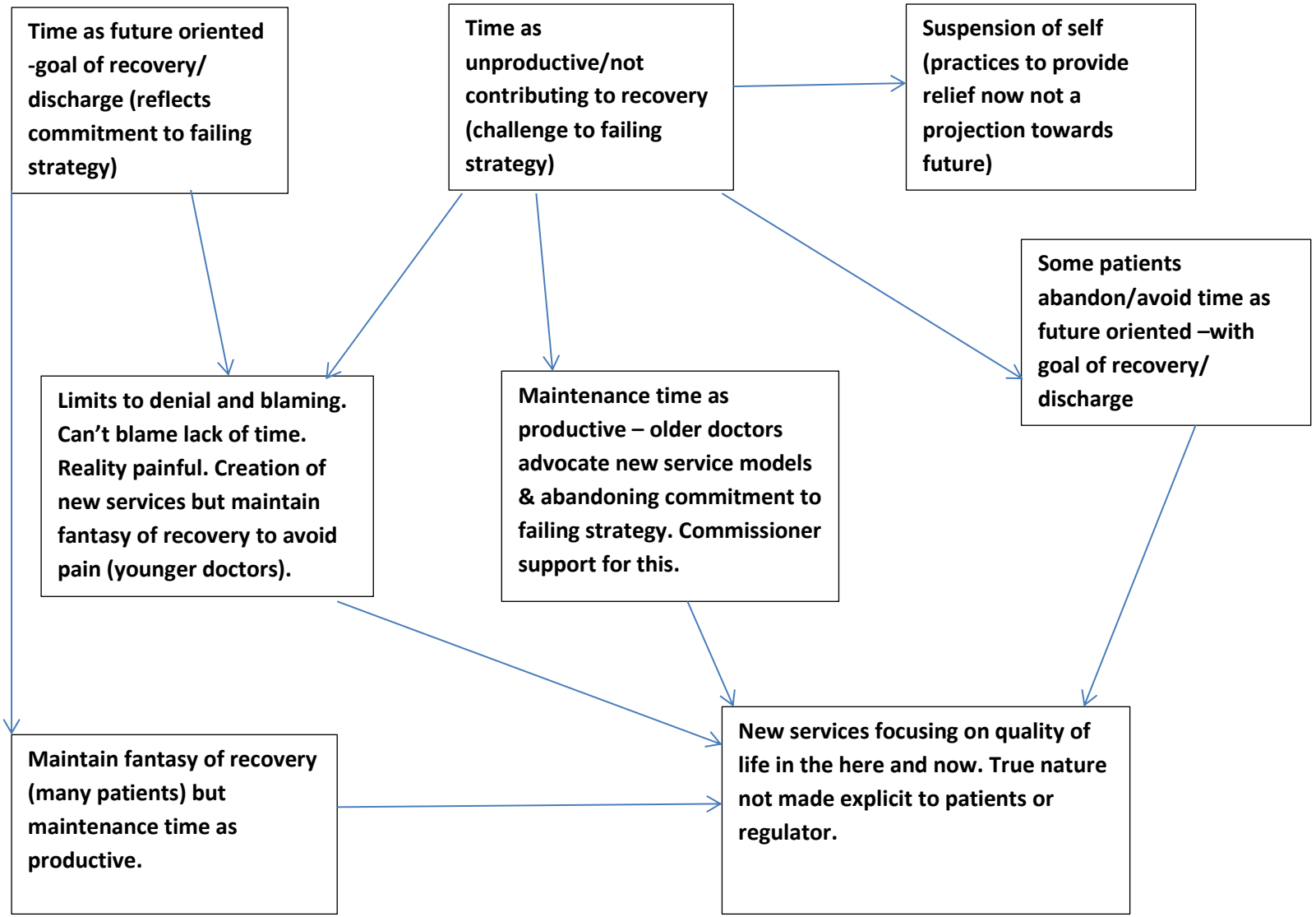

Table 1 Data extracts

First order categories	Data extracts	Second order themes
Pressure to pursue failing strategy by third parties	*There's the [regulator] now scrutinising, there's solicitors, commissioners and all these people who are interested in active therapeutic programmes and how do you negotiate all those expectations for the patients who really won't be moving on any time soon? ID30* *having commissioners and Trusts saying people have only got to stay two years, be ready in another five years ID17* *CQC [the Care Quality Commission, a regulatory body] expecting patients to have full therapeutic programmes which may not be appropriate for certain long stay patients…. sometimes their solicitors, the tribunal expect you to be doing just as intensive work with somebody who's been in for fifteen years as has been in for one year. ID12*	**Time as future oriented -goal of recovery/discharge**
Denial of failing strategy (staff)	*I'm always a therapeutic optimist! (laughs) … I would always think that we'd be trying to keep moving people forward…even with [names famous patient who has been in secure care for over 50 years] we offer him some psychological help… and then he declines. ID4* *You know everything that we seemed to have gained in the last few years about recovery and about participation and so on has been about motivating people to change because of the prospects of something better than custody and being locked up and if you were to take a unit where you had deprived anyone of those opportunities it would be very difficult to keep positive relationships and to keep people motivated.ID2* *you never know what might change in somebody's life or whether there'll be a new drug that will come out for example, that we'll have much better treatment .. sometimes therapeutic optimism and therapeutic hope can be reinvigorated for both the patient and the team by a change of team ID27* *[A] unit shouldn't abandon all therapeutic hope. I mean it might be that you have to just say it looks like 'John' is going to be here with us for a very long time … anyone who's been around a for a while, you do see people change and unexpectedly…You can never give up. ID5*	

Table 1 Data extracts

	that sense of optimism has to be there because detention's not about warehousing people or just containing people, protecting the public from harm. I think at the core of what we do is treatment and care and for this there needs to be optimism. ID25	
Denial of failing strategy (patients)	*you get psychology, you get social skills… CBT, done that, just doing that one now… It's brilliant, all the courses I've done are brilliant. [When I get out] Working outside for the RSPCA looking after animals… volunteering and my own flat A1(P)* *He just offered me no hope …. the judge turned round and said…'I'm gonna actually, er, advise the Home Office that you never be released'… It's getting brighter now. Yeah. Because of all the changes in nurses' attitude and recovery… In a proactive way, like moving you forward, not just keeping you detainedA3(P)* *on the empathy level … I was never gonna change my ways anyway because as soon as I get out of here, see it might sort of like, look like I'm listening to you and all that and I know what you're talking about…but listening …and actually, like, changing my ways are two different things… it's a game…if you suck up and all the rest of it, yeah? And if you sort of do what they're asking of you, you get out. But if you buck the system or anything, it condemns you. A3(P)*	
Patients dependent on clinicians	*you have face-to-face time with staff … They said, 'Well done. Very positive. Well done, your behaviour. .. Very proud of you, very positive, very proud of you, happy, so well done, ward round, well done, well done'. I've improved … I haven't lost my temper, I haven't shouted. I've joked with staff– normal jokes, messed around, yeah, had fun, had fun and joked but I've been quite careful not – you know, jokes and fun but not stuff that's not appropriate…Don't want them to think that I'm getting worse and I'm getting highs… because they might then write that down and that will go on my record and that will be bad R2(P)* *I like the staff. … The nurses, staff nurses, staff – they tell me how to stay calm... Before I was naughty. I kicked the staff… I like it here. I like it here. It's good. .. staff are helpful. I talk to the staff. .. If staff tell me off, I don't do it again…the staff are helpful...staff are nice. They help patients. B3(P)*	
Alternatives wholly bad	*asylums were places where you could live a life away from society in a very contained bubble and not be put under any pressure whatsoever to engage in treatment… I don't want us to go back to that way of being. ID10*	

Table 1 Data extracts

	You was sent to hospital, into [high secure hospital], 30, 40 years ago, and that's where you stayed until, maybe, you died, or they released you. That was it. There was no, 'Send him to a unit and he'll work there and then get out eventually.' There was none of that. It was – there was – there was a minimum of drugs there, in the prisons, in hospitals. If you were crazy, they, they would, like, electrocute you, shock you, or they'd cut a hole in your head, or, or chuck you in a, in a suit, inject you, when you're mad. Do you know what I mean? Things were, like, diabolical, you know. As time, as, as time's gone by, things have changed. N4(P)	
Blaming patients	*The majority of ….patients we've got have got a severe and enduring mental illness with gross loss of insight and treatment responsiveness. … We've got one who is a rip-roaring psychopath …he's going to be in high secure for twenty plus years and really difficult – I wouldn't want him managed in any other environment …..he's had loads of treatment but he's still risky ID11* *patients who are really quite treatment resistant in terms of their mental illness and have little insight and aren't willing to engage with the sort of therapeutic interventions that are thought to be beneficial to them.ID27*	**Time as unproductive/not contributing to recovery**
Blaming staff	*I'd finished everything and just waiting for this and waiting for that. This is where time just gets run out…. But on the tests that I've done, here when I first came here, I've dropped right down. Even the psychopathy band's dropped down…. I really get to the point where, you know, the only people that seem to see a problem are the professionals… we should be going back into the bloody community. Damn it K2(P)* *I want to get out there and make a stand with what I've got left of my life. Well, it's – the doctors have seemed to be a bit obstinate, a bit stubborn. I, I'm not saying I'm going to attack people and things like that or smash everything up or... anything like that. It's just after all this time, I don't want to be going through any more of it because it's, it's just like a constant pressure that's building up. .. I even tried to set fire to the place…. have you see the programme, 'Escape to the Country'? Well, I watch that and I pick up on all the art details and all the decor of the houses and I'm constantly looking for new ideas. My dad's house would bring about £200,000… S3(P)* *Well, they, they said that, erm, this place said that I had a personality disorder, which I've*	

Table 1 Data extracts

	always disputed. … I was put in seclusion to begin with, and then they said that I was so psychotic that, er, they were moving me to the mental illness part. F5(P) *I feel I'm just rubbish. I can't say it no more but I feel rubbish. Do you know what I'm saying? I feel empty. … The way that I say, I feel like shit. Do you know what I'm saying? That's the one. I feel like shit. Seriously, I feel like nobody like need to be in a place like this like for so long, from - right. ..Why don't they give me another chance?... I don't feel comfortable. I can't breathe. N1(P)*	
Clinicians dependent on patients	*treatment resistance… they just aren't equipped to develop empathy, develop risk reduction… what I've found has been really important is to celebrate the small changes. You know, you come to [team meetings] and say, [John] spoke to me today, he told me it was raining and not to get wet. [John] doesn't speak to me from one year to the next so this is enormous…there's someone now… He's a difficult one really. I think we thought it would be fine but I think over time he's not really engaged with anyone in particular… and the staff really struggle with that. ..when he did start to engage it was like really kind of uplifting and we were all kind of excited and motivated, really kind of hopeful. Yes it used to affect the staff quite a lot kind of when we got used to the cycle and kind of when he disengaged we'd just get that hope that he'd engage … and thinking well, we're gonna crack it this time. And it is, it's a real kind of feeling that it's difficult. FG – ID#* *I mean the issues about staff burnout are quite pertinent as well when patients are not getting better and frustrating staff and things like that. ID28* *we as a clinical team…. expect patients to have developed some sort of insight into their mental illness, into their offending… I think it does demotivate them[staff]… the chances of him having insight in the future is going to be quite low ID19*	
Monotonous lifestyle	*We get asked all the time, are they institutionalised, doctor, is this what's happened? Implying that they're passive recipients of a quite dominant sort of institution that's quite malign. No I think they're often, the group that are really bad at looking after themselves and often don't want to look after themselves are quite content with a basic level of functioning which is just about getting your basic needs met and that's it. And it's a retreat from mainstream society. It's*	

Table 1 Data extracts

	a sort of familiar retreat. ID# *Very structured, very boring. If they made activities all the time everyone would go all hyper and we'd all get excited and end up fighting each other..... If we played bingo every night right? Everyone would get excited, fighting over bingo prizes. This is the best it gets, it's not going to get any better. It's no good thinking about how you are going to get out all the time… I could live the rest of my life. See this is a waiting game isn't it.. You wait around all the time for things. .. you wait for your dinner, you wait for things to be served… the whole waiting game here is that it will happen but it happens at set times ..Everyone can sell drugs. They can sell their medication…. It happens all over the hospital…. Once you used to get caught with it in your system they would suspend the whole entire ward. They would go around and search everyone. Now they find it, they just leave it. … Because it was a waste of time. They used to a massive search for a little piece of weed. A2(P)* *I bloody try a bit of old herbal haze. Too strong for me but then I did it a bit… in my system they'll find caffeine, taurine, ammonia…. We've been smoking dodgy tobacco; we've been drinking energy drinks and stuff like and we have people here who takes everything away from us F6(P)* *not very much happens to my day and there is, there is monotony, that means that when I wake up... I'm faced with the same thing today that happened yesterday and for the past 20 years so there's not much variety. So there is a feeling of stale… of nothing new. There's no stimulation, it's hard to find things that help fulfil my self-fulfilment, give me some self-fulfilment. There are things that make you more comfortable in the environment and there's a nursing team and my peers, the games we play and the food we eat, the team spirit, are things that cushion that. Yes. So most of my days are the same ... most of us are sitting around all day doing nothing. S3(P)* *I've done it all. I've been to every single area and I've done it all for like, the last 21 years, do you know what I mean? It's just like, it's boring now. ..I just don't wanna do nothing. I just wanna sit in a chair and sleep. I've had enough of doing things just for the sake of doing things R6(P)*	

Table 1 Data extracts

	I don't think that psychiatrists are that interested in the effectiveness really to be perfectly honest. I think what they're concerned about is risk ... Our treatments are fairly feeble actually in their efficacy. ID22	
Status quo bad/ 'enhanced recovery' wards better	*There were so many kids like when I say kids, like in their 20's. They were all swapping medication, they were all smoking at night time in the toilets. K1(P)* *they used to pick on him because he's 58, scruffy bloke, only showered once a week and like they'd just pick on him and it's out of order and the amount of time me and [friend's name] pulled them and told them just leave him alone man but there's talk that he could be coming over here but if he came, he'd love it over here. It weren't just him, there was bullying for, lots of people were being bullied. …. It's um more settled, majority of the patients are older like myself um we all help each other out, all of us help each other out. F2(P)* *I went first into hospital, psychiatric hospital, when I was 16. I've been most - since then I've been in hospitals or prisons…. I'm 52 now…Well, I feel now that people care. They've cared for me all along but like here, it's just fantastic. I've never been to a place like this before. …I'm a bit institutionalised. H1 (P)* *A larger focus on sort of, ward-based activities, community activities, maybe cooking or plan of the day meetings, current affairs groups etc. So a real sense of a community ID9* *It's a smaller ward. It has accommodated the fact that it will have a group of higher profile and longer stay patients, there for an extended period of time. The staff are sensitive to the risks that exist within the hospital to these men, be it from telephone calls, letters or comments that other patients make. ID8* *I think the people who say warehousing have a point. I can see it might look like that. I always think though you have to be straight with people. I think patients in my experience are really good at seeing through the false optimism of the clinician. And you know, yes they want hope but actually they don't want rubbish and people who've been around for a long time are very, very sensitive to attempts to…not to mislead them because that's wrong. ID18*	**Maintenance time as productive**
Older clinicians advocate abandoning failing	*You can't let them into the community but they can live within an environment where you can just do farming or do whatever. This is the part of the old hospital like (name) … where there*	

Table 1 Data extracts

strategy	*was a part of the hospital for those they were detached maybe from reality… they just love animals and just do things and… spend all the day happy there. ID21* *and some people say it's a bit old-fashioned, people going to work on a farm or having day trips to the beach or something like that to improve their life, you don't do that here anymore. That was what you did in these big total institutions that we now say they shouldn't exist anymore. But the reality is they do exist, just without the quality of life! (laughs) ID23* *I think what we need to do is try a process of re-education and training which focuses a bit more about on how complex things are and managing negative feelings in residential settings because … they are very much focused on positives and 'getting better' and which leaves out being able to talk about negative things. And I think if we skilled up staff to talk a bit more about negative things, negative feelings towards the patients, negative feelings about what the future holds for the patients…And would also I think allow them to talk about, you know, just to validate I think the very real difficulties of their experience. ID17* *some people can still find some work and fulfilment in their life, even if they're detained for life in custody ... You never, ever give up hope …for some people for whatever reason …they will not get out … That's the reality … and it would be really good if they didn't do just law degrees because that's what they tend to do so they can have very interesting tribunals. But how else do you fulfil yourself? It should be possible …So no, it's never about just warehousing. (ID16)*	
Support for change from commissioners	*Commissioners do not commission long-stay medium security. They do really, because the people are having it, but they don't officially. ID3* *the commissioners, I've found to be very, you know they recognise this is one of the roles of our service and I haven't felt under any pressure from commissioners to move people ID27* *there are people in the long term service who don't need it but there's nowhere for them to go …that's probably more acceptable than long stay actually, continuing care. Because you've still got, it's a legal term as well isn't it, health has responsibility, financial responsibility, continuing care so just thinking outside of the secure environment, there's the use of that terminology. So that might be more acceptable label… I don't think you'd have a problem selling so much to*	

Table 1 Data extracts

	commissioners. ID32 *there is a group of people who can sit in secure services and I would have to say predominantly it's people who have sex offending as their background... What they need is the relational security of staff who are working with them and around them who know of the risk that they represent to others... What they would need is a structured accommodation...and 24hr supervision… And their quality of life would increase greatly. ID33*	
Patients (willing to)avoid/abandon 'recovery'	*patients can sometimes I think sabotage … because I think at some unconscious level they don't want to move on and they become very attached to the service and the people within the service and consequently they will sort of say all the things that suggest that they want to move forward but in fact I think at a deeper, unconscious level or unspoken level they do things that you know, are going to keep them here if you like. ID27* *Every time I ask for a tribunal right, it falls on an awkward day when I'm busy…. I'm just going to take it step by step…. It's helped me a lot by not expecting things F2 (P)* *I guess if it means that my risk will never be manageable to the point where I can safely be in the community, then the best quality of life that I can expect or hope for… people are always saying while I'm here that I'm still a risk. My risk hasn't changed, that I still need to be detained, that I'm still unwell, I'm still disordered, that I still need further treatment… it's interminable, it's protracted and complicated… If somebody said it's either stay in [this hospital] until you die or go to a place where you have more freedom, more autonomy… that would be preferable…[where]. .. people seemed to have a sense of belonging and purpose. Which is a big difference than being here when the most purpose I have is a competition to have a game of pool to see if I beat somebody else. R4 (P)*	**Avoidance of time as future oriented -goal of recovery/discharge**
Clinicians conflicted	*I have one particular person who has either been in prison or medium secure for 27 years. However, that guy has an extremely severe personality disorder, extremely severe mental illness. He has committed one murder and two attempted murders... I personally do not see this as a problem…It becomes a problem if you are not able to offer appropriate treatment. We do offer appropriate treatment…. even if someone's been there for twenty years you should still be trying to do something even if it's on a very sort of basic level … you may not be doing actual psychological treatment but you could still be working with an occupational therapist …looking*	**Time as future oriented / Maintenance time as productive**

Table 1 Data extracts

	at behaviours, communication skills or whatever it is …..we all pay lip service to the fact that we do .. every six months [a] review [for patients who are not going to move on]….you can't just put a statement up, 'this person in long term medium secure'….I'll adjust the treatment as best as I can as I go and if they need to stay they need to stay…Everybody knows [this patient won't be going out] yes, well we even probably do talk about it, but you just have to keep reviewing their care ... and what was a hopeless situation a couple of years ago you can review that person and say well actually they have made some progress. ID3. *you're not going to put someone through say the illness awareness group for the third time. … at one point you say, this person's done this a couple of times, stop. No point having one-to-one psychology ad nauseam. So there will be a shift to long sort of chronic just quality of life stuff… doing more work with staff, supporting them and understanding and dealing with them managing with the long stayers …we don't give up easily … We could see progress, we could see even a very slow progress ID15* *A home for life, this is how patients were moved in…..what I don't want this to turn into is warehousing. That would I think be soul-destroying for everyone involved…. it's doing things differently that you know, it's some hope, it's some chance, it's some slightly different angle that you're going in and that just might be the gateway into somebody actually managing to move on. FG 3. ID 3.1* *I think there's a bit of optimism so it's up to the clinicians to really make sure that they do take that opportunity …It's about maintaining hope but being honest with people as well. .. we've called it Enhanced Recovery Service……we want to maintain some realistic hope for some guys, but we've also got to make it pleasant and a good quality of life and optimising people's recovery for some of those guys who aren't going anywhere and women, in the future… And a new environment with a different focus can make a difference to people... It's really just keeping an open mind as to if there is any progress and being a bit creative about whatever interventions you might use to try and prise the door open a bit more.' ID5*	