Everyday ordinariness, neglected but important for mental health nurses' therapeutic relationships: an initial exploration for applying Daniel Kahneman's two systems of thinking

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No funding was used in preparing this manuscript. No conflicts of interest are reported.

No ethical procedures were undertaken as not deemed necessary.

Acknowledgements to Ada Hui for her support and comments on early drafts.

Key words: mental health nurses, relationships, engagement, Daniel Kahneman, unconscious and conscious thinking,

Abstract

Mental health nurses undertake difficult and complex roles. Therapeutic relationships and engagement between mental health nurses and people experiencing severe mental ill-health provides the core purpose and rationale for such mental health care. These relationships are influenced by factors outside of frontline mental health nurses control. They are difficult to define or describe with clarity, have limited 'quantitative' evidence of effectiveness, and are frequently not experienced as therapeutic. This paper presents some initial ideas regarding 'everyday ordinariness' using psychologist Daniel Kahneman's two systems of thinking as a focus for understanding and potentially improving mental health nurse practice, and therapeutic relationships and engagement.

Aims

This position paper has three aims. Firstly, to propose Daniel Kahneman's 'two systems of thinking' (Kahneman, 2011) as a useful and practical addition to the conceptual framework of mental health nurses (MHN) in supporting their development of therapeutic engagement and relationships with people experiencing severe mental ill-health. Secondly, to suggest that MHN

therapeutic engagement occurs in two important and potentially therapeutic milieu. These being the neglected milieu of everyday ordinariness and the widely promoted milieu of 'evidence based' structured, therapeutic engagements – therapy e.g. cognitive behavioural therapy. Thirdly, to propose a framework which links the two systems of thinking and everyday ordinary contexts of therapeutic engagement for MHN to focus and promote their relationships with people experiencing severe mental ill-health.

Background

The current focus for MHN upon therapeutic engagement was promoted by Hildergard Peplau's theory of interpersonal relations as the foundation of psychiatric nursing practice in the 1950s/60s (e.g. Barker & Buchanan-Barker, 2011; Lakeman & Hurley, 2020; O'Brien, 2001; Wand et al., 2022). The shift in relationships from custodial care to therapeutic engagement and relationships between MHN and people experiencing severe mental ill-health has not been and is not, a smooth one (Barker & Buchanan-Barker, 2011; Delaney et al., 2017).

This position paper focuses upon MHN relationships and therapeutic engagement within acute and secure hospital care (A&S care), as this is where issues of the shift from custodial control to therapeutic engagement as the central focus and rationale are most acute (Cutcliffe & Happell, 2009). It also applies to 'registered' MHN and to unregistered, often poorly trained staff (e.g. health care assistants, nursing auxiliaries) who provide much of the daily engagement with service users, whilst being (in theory) supervised by MHN.

Therapeutic engagement/relationships and MHN

How MHN engage with people experiencing severe mental ill-health (subsequently referred to as people) makes an indispensable contribution to how A&S care is perceived and its impact upon their 'recovery' (e.g. UK, Department of Health, 2006; Molin et al.,

2016; McAllister et al., 2021a; Delaney et al., 2017; McCrea, 2014; Reinius et al., 2023; Staniszewska et al., 2019; Cutcliffe et al., 2015). Friendly (ordinary) informative, calm and caring engagement by MHN is valued by people in hospital (Molin et al., 2016; Reinius et al., 2023; McAllister et al., 2021a). However, too often peoples' experiences of A&S care are of unfriendly, hurried, dismissive engagement from MHN who focus upon giving medications, administration and office work (McAllister et al., 2021a; Molin et al., 2016 & 2020; Farrelly et al.,2014; Hartley et al., 2020). MHN engage with people receiving A&S care in demanding, often chaotic contexts (Molin et al., 2016; McAllister et al 2021a; Hartley et al., 2020) and experience many demands in their work, which compete with providing therapeutic engagement.

MHN regard the therapeutic relationship as the core of their professional identity and practice (Jackson & Stevenson 2000; Browne et al., 2012; Barker, 2001; McAllister et al., 2021a; Molin et al., 2020). Yet when asked to explain what the MHN therapeutic relationship is they often appear uncertain, unable to convincingly explain what they do and how it works, or not, to aid recovery (Jackson & Stevenson 2000; Hurley & Lakeman, 2021; Browne et al., 2012):

> *"Despite considerable efforts the therapeutic relationship has been difficult to define and even more difficult to operationalize and study"* (Browne et al., 2012, *p840).*

Several factors underpin uncertainty in this core element of MHN professional identity, role and practice (Wand et al., 2022).

Firstly, MHN engagement with people in A&S care is wide ranging, occurs 24 hours daily, meeting a wide range of purposes. For example, helping patients undertake necessary daily activities including self-care, nutrition, exercise, behavioural management; 'professional' and 'ordinary' engagement, such as sharing personal information ('self-disclosure' (Unhjem et al., 2018) activities, humour and 'banter' (Molin et al., 2016 and 2020; McAllister et al., 2021a; Barker, 2001; Browne et al., 2012; Delaney, 2017; Lakeman and Hurley, 2020; Jackson & Stevenson, 2000; Wand et al., 2022). MHN may also, but infrequently engage with people in goal directed, focused, evidence based therapies e.g. cognitive behaviour therapy and psychotherapy (e.g. Jackson & Stevenson, 2000; Hurley et al., 2020).

Secondly, a wide range of 'constructs, sub-constructs and attributes' proposed as characteristic of the therapeutic relationship such as conveying understanding and accepting individuality have been theoretical, complex and difficult to operationalise as MHN applied practice (Brown et al., 2012). For example, self-reflection (McSherry et al., 2015) or Delaney et als' (2017) process of: centering yourself – sending intent – empathy – attunement – decoding and crafting a response. This difficulty in operationalising MHN therapeutic relationships is associated with a lack of quantitative research evidence for their impact. Research and development of measures regarding the impact of MHN therapeutic relationships for peoples' outcomes has been of poor scientific quality (Feo et al., 2022) and continues (e.g. Delmet et al., 2021; Taylor et al., 2022). Despite this lack of quantitative evidence regarding MHN engagement, significant qualitative evidence is available (e.g. McAllister et al 2021a; Molin et al., 2016 & 2020; Reinius et al., 2023). In addition, and perhaps as a consequence of poor conceptual clarity, the range of interventions to improve

therapeutic relationships is surprisingly limited and shows limited efficacy (Hartley et al., 2020; Molin et al., 2016).

> *"The evidence base for methods to support nursing staff to develop and maintain good therapeutic relationships is poor, despite this being a key aspect of the nursing role and a major contributor to positive outcomes for service users"* (Hartley et al., 2020, p1).

Thirdly, MHN working in A&S care practice in emotionally and professionally demanding contexts. They are expected to 'regulate' their emotional expression to match variable service user contexts and needs (Hammerstrom et al., 2022; Jackson & Stevenson, 2000) whilst negotiating issues of differential power over people receiving A&S care (Cutcliffe & Happell, 2009). Consequently, the experience of personal anxiety, stress and sometimes burnout is associated for MHN with 'emotional labour' involving the suppression of their own emotions whilst caring for people (Mann & Coburn, 2005; Edward et al., 2017).

MHN also have to respond to expectations and demands from more powerful mental health care colleagues, which can compete with their efforts and, possibly inclination, to engage therapeutically i.e. provide reasons for not engaging. For example, hospital managers (and professional colleagues) look to MHN for maintaining hospital order including through enacting behavioural controls, administrative and domestic routines (Hurley & Lakeman, 2021; Lakeman & Hurley, 2020; Hui et al., 2020; McCallister et al., 2021a; Wand et al., 2022). Maintaining hospital order by enforcing blanket rules to groups of people receiving A&S care (e.g. the removal of phones, ligature materials, access to fresh air and activities) are controlled by MHN and difficult to integrate with developing therapeutic relationships (McCallister et al., 2021a; Jackson & Stevenson, 2000; Cutcliffe &

Happell, 2009). It is perhaps not surprising that some MHN withdraw from therapeutic engagement, becoming emotionally distanced from people and instead focus upon 'office work' and the maintenance of hospital order (McCallister et al., 2021a; Hui, 2017; McCrae, 2014; Molin et al., 2016).

In view of the contextual and conceptual complexities described above, it is perhaps not surprising that therapeutic relationships between MHN and people receiving A&S care are often not experienced, are ill-defined, lack an established quantitative evidence base and engender uncertainty for MHN and people receiving such care. Consequently, leading to difficulty for MHN nurses to explain what they do; both to themselves – in terms of having an explicable professional role and identity - and to others (Barker, 2001; Hurley & Lakeman, 2021; Lakeman & Hurley, 2020; Barker & Buchanan-Barker 2011; Desmet et al., 2021).

Human interaction is entirely a function of our brains' operations, much of which is not accessible to our conscious awareness or (usual) scientific endeavours. Hence Daniel Kahneman's work applying neuroscience - the study of brain function - into everyday ordinary human social functioning is applicable and potentially useful.

Design and method

This is designed as a position paper using the following methods. The Background presented a narrative review of obstacles and impacts for MHN engagement with people receiving A&S care. Subsequently, summaries of Daniel Kahneman's two systems of thinking based upon his book Thinking, Fast and Slow (Kahneman, 2011) and everyday ordinariness

are presented. The two systems of thinking is then developed and applied to MHN role and practice in two ways:

- As a focused approach suggesting that expectations placed upon MHN, 'priming' and 'confirmation bias' influences MHN engagement with people receiving A&S care in either positive, or unhelpful ways;
- As a broad conceptual framework to support a wider, recovery focused approach to MHN engagement. Situating MHN engagement on a spectrum from everyday ordinary social engagement to professionally bounded and structured engagement i.e. therapy. Thereby, linking neglected but important ordinary ways of thinking (both intuitive and conscious) to ordinary ways of engaging and living.

Daniel Kahneman's two systems of thinking

Daniel Kahneman the (Nobel Prize winning) psychologist made the impact of neuroscience and brain function accessible to the public with his description of the two systems of thinking in his book 'Thinking, Fast and Slow' (Kahneman, 2011). System 1 thinking is automatic, rapid and involving little sense of effort or of voluntary control. System 2 thinking is slow, effortful and allocates attention to effortful mental tasks. For brevity we call these intuitive or intuition (system 1) and conscious thinking (system 2). Only conscious thinking can construct thoughts in a logical, orderly series of steps. The interaction between intuitive and conscious thinking is central to this paper and central to what we ALL do when we are 'behaving'.

Our intuitions perceive our surroundings remarkably rapidly, developing impressions with little perceived effort and suggests thoughts, and actions, which are not consciously 'worked

out'. Our effortful consciousness thinks of itself as being in control despite largely accepting and relying on effortless, automatic intuitive operations. When we are awake both systems are working, intuitions effortlessly and conscious thinking in 'lazy' low effort mode.

> *"System 1 continuously generates suggestions for system 2: impressions, intuitions, intentions and feelings. If endorsed by system 2, impressions and intuitions turn into beliefs, and impulses turn into voluntary actions" (Kahneman, p 24). …..In summary, most of what you (your system 2) think and do originates in your system 1, but system 2 takes over when things get difficult, and it normally has the last word" (Kahneman p.25).*

For much of our everyday life this division of mental labour works efficiently and well. Intuitive thinking gets us through everyday ordinary life with little perceived effort and conscious awareness monitors (within its limited capabilities) and tries to stop inappropriate intuitive suggestions e.g. losing one's temper or 'jumping to (unwarranted) conclusions'.

Much of Kahneman's work is focused upon the problems of intuitive thinking: biased and heuristic thinking (mental shortcuts) which we rely on to navigate life but which can produce problems for our decisions and understanding.

System 2 also has its problems. Conscious thinking whilst necessary to construct a logical argument and compute statistics has limited effortful capacity and generally~~, and~~ by preference, runs in 'lazy' watchful mode over intuitive thoughts. Kahneman illustrates this limited capacity: try walking at an easy pace and multiplying 17 times 24. Our brains often find this effortful task difficult to combine with the largely automatic function of walking, which slows or stops. Perception can also be badly affected if conscious thinking is undertaking an effortful task. The 'Invisible Gorilla' task (Simons & Chabris, 1999)

demonstrates this well. Around 50% of people fail to see the person in a black gorilla suit pass between two teams when they are asked to focus upon counting the number of times the ball passes between the players dressed in white. This has clear implications for what MHN 'see' and give attention to e.g. when undertaking close observation of suicidal people, where in balancing safety/containment and therapeutic engagement, the former is likely to be prioritised (O'Brien & Cole, 2004, see also Table 2 below).

Kahneman's two systems of thinking gives intuitive thinking first mover status in initiating human thoughts and actions. Conscious thinking takes over when things go wrong or in a deliberate and practiced manner, as in academic discussion or psychotherapy. As Kahneman summarises "…most of what you (your system 2) think and do originates in your system 1, but system 2 takes over when things get difficult, and it normally has the last word" (p, 25). This paper suggests system 1 thinking is largely neglected within current MHN theory and practice.

Everyday Ordinariness

Felski (1999) in a wide ranging critical review describes everyday life in terms of duality, the essential, taken for granted continuum of mundane (daily) activities that frames our forays into more notable, and exciting activities of living. According to Felski (1999) everyday life is a 'puzzling' idea:

> "Because it has no clear boundaries, it is difficult to identify. Everyday life is synonymous with the habitual, the ordinary, the mundane, yet it is also strangely illusive, that which resists our understanding and escapes our grasp" (p 78).

We all have an ordinary life but these are not celebrated or much noticed. It just happens – until it doesn't. This invites comparison with the work of MHN who carry out tasks required for maintaining ordinary life and ordinary hospital routines largely decided by others e.g. medical doctors and managers, who undertake more notable and 'important' tasks (Wand et al., 2022; Lakeman & Hurley, 2020).

For people experiencing severe mental ill-health, whether long standing or acute, it is axiomatic that they experience loss of, or severe disruption to their engagement in many ordinary aspects of life (Molin et al., 2016). The ordinary, everyday personal and social routines which make up people's socially bounded and engaged life including: self-care, personal appearance and presentation, sociable discourse and co-operation with neighbours, work colleagues and families are often (sometimes severely) disrupted.

Thus everyday ordinary life provides the unavoidable, inevitable but largely ignored shape to all of our lives, including people receiving A&S care (Felski, 1999; Molin et al., 2016). This is also apparent in mental health care where the focus is upon engagement and knowledge based upon system 2 conscious logical, causal thinking - scientific thinking, especially in psychiatry, psychology and management. Consequently, neglecting system 1 intuitive thinking that involves the development of 'tacit knowledge' and most everyday ordinary, unavoidable and generally valued engagement.

Intuitive thinking, a focused application: expectation, priming and 'confirmation bias' in MHN engagement

Conscious expectation (and its intuitive effects) and priming are two phenomena which contribute to a general confirmation bias: the tendency to search for, to see, recall and interpret information in a way that confirms our existing ideas, beliefs and actions.

For example, Barker (2001) noted that a unique aspect of the Tidal model (amongst other recovery models) is the use of people's individual narratives and experiences of their mental distress held in records MHN keep on them. The current primary expectations for MHN (which influences how and for what they engage with people in A&S care) is to observe people for symptoms and diagnostic related problematic behaviours (e.g. aggression) requiring containment. These expectations, as seen in the Invisible Gorilla experiment can effectively make them 'blind' to other actions i.e. recovery related behaviours.

In addition, priming occurs when an observation or action makes particular following actions or observations more likely in the short term. This measurable influence upon our thoughts and actions occurs without our conscious awareness. One well- known study of priming showed university staff to be more generous (during the 'eye' weeks) with the Department's 'honesty box' for beverages when a poster showing alternating pictures of flowers or nature scenes and eyes was placed above the box, despite participants being unaware consciously of the pictures or their differing levels of generosity.

Mental health care services/organisations will have differing policies for inducting staff. Some, probably most, will give information related to the diagnosis, symptoms and risks presented by people receiving A&S care and insist that protective, risk management procedures (including restrictive interventions) are learnt before working with people in A&S care. Some may ask new staff to 'get to know' the individuals cared for by talking to

them, observing the unit's routines and becoming familiar with the range of patients' interests, difficulties and abilities.

Table 1 shows hypothetical examples of how a MH unit office might present - visually display - information regarding John Smith.

John Smith	Paranoid Schizophrenic	07.03.1992	Often becomes agitated and shouts when having auditory hallucinations. Neglects his care and constantly asking for cigarettes	Swears at staff, may be violent to staff who present requests or deny cigarettes. Needs 4 person supine or prone restraint when violent.
John (likes to be called Johnny) Smith	Is a skilled craftsman and cabinet maker. Used to play football for his county team, in goal. Loves a pint and chat in his local pub when he feels secure enough.	Johnny will be 31 years old on the 7th March next year.	Likes to talk and 'have a laugh' with staff who sit and have a chat. Likes to talk about football, his work and his family.	Will tell you about the postmen who torment and threaten him, if you ask him who or what he is shouting at. See security plan

Table 1 is intended as a (very incomplete) illustration of what this might look like and lead to; expectation, priming and confirmation for MHN and other practitioners of Johnny's ordinary and extraordinary life experiences. Expectation, priming and confirmation bias effects may lead staff inducted in a safety first approach, to be focussed upon and ready to respond with some anxiety to John, and not attentive to his life experiences and character in a more ordinary social sense. The top version of John will provide expectations and evoke priming, supporting a confirmation bias that is likely to lead to hesitation to

engage for MHN, as staff observe Johnny closely for signs of risky behaviour e.g. agitation and having to respond.

Everyday ordinariness and two systems of thinking in developing a framework for MHN therapeutic engagement: a broad perspective

People receiving A&S care report experiencing ordinary sociable engagement (e.g. self-disclosure, humour, banter and shared activities) as therapeutic (Reinus et al., 2023; Jackson & Stevenson, 2000; McAllister et al., 2021a; Molin et al.,2016). Thus MHN engagement which is experienced as therapeutic appears synonymous with 'strangely illusive' everyday ordinariness, described by (Felski, 1999). An illusiveness, perhaps, demonstrated by the difficulty MHN have in describing and defining their role and practice.

Some MHN theoretical work has referenced ordinariness within MHN engagement (Molin et al., 2016; Barker, 2001, Browne et al., 2012, the latter two tangentially). Barker (2001) noted that MHN practice as part of the Tidal model of recovery 'may appear ordinary' (p.238), and Browne et al (2012) suggested that MHN engagement (referred to as a 'variety of psychotherapies') occur "not only on the couch (but) in the supermarket, the seclusion room, in the kitchen and on the street" (p.842).

However, for Jackson & Stevenson (2000) ordinary is central to their conception of MHN therapeutic engagement. Table 2 below maps Jackson & Stevenson (2000) with the two systems of thinking. Jackson and Stevenson (2000) collected the views of a range of mental health professionals and people receiving A&S care regarding MHN relationships and engagement. MHN were thought to be in the best position to 'predict' what people's socio/emotional needs are at any moment, assessing their 'moment by moment' changes in

mental state. To 'know' which of three interactional roles: friend - friendly professional and more distant professional (from 'ordinary –me' to 'professional –me)' is most appropriate at any moment and be able to move easily between them. Ordinary (me), everyday relaxed 'small talk' engagement being delivered largely intuitively and more distant professional interactions (i.e. therapy) being steered by conscious effort.

Table 2, Jackson & Stevenson (2000) MHN engagement mapped to two systems of thinking

Core category – knowing you, knowing me		
Three subcategories – the three me's (and their dimensions)		
Ordinary me	Pseudo-ordinary/engineered me	Professional me
Depth of knowing: intimate Power: control through friendship Translation: lay language Time: informal contact	Depth of knowing: semi-intimate Power: control through deliberate self-disclosure Translation: professional concepts in everyday language Time: semi-structured	Depth of knowing: distant Power: control through being the professional Translation: jargon Time: structured
Two systems of thinking and MHN engagement		
Engagement guided by intuitive thinking with lazy conscious oversight, feels effortless and comfortable. Including banter, humour, self-disclosure and informative responses to questions. System 1 has no means of alerting system 2 when it gets into trouble	System 2 'waking up' to more effort required in guiding the engagement, may become noticeable to communication partner as hesitancy. System 2 may not recognise its conscious, planned approach is required in any particular situation	Engagement is under system 2 effortful control, is consciously planned, and control is usually obvious to communication partners. Therapeutic engagement is structured and setting becomes contained and controlled

Note: the top section above is replicated from (Jackson & Stevenson, 2000, p. 381)

Discussion of ordinariness - ordinary socialising - small talk - largely intuitive relaxed interaction in A&S care may seem unimportant (and often regarded and rewarded as such)

when placed against therapy – conscious and effortful interaction. These are merely different, both vital - a continuum - of approaches for supporting recovery to ordinary life and amelioration of distressing experiences (Jackson & Stevenson, 2000; McAllister et al., 2021a; Molin et al., 2016).

Table 2 encompasses the role of intuition in the complex practice of MHN engagement. The following two examples illustrate therapeutic influences of intuition within psychotherapy and an acute MHN context. Rober (2020), a Dutch family psychotherapist uses a practice example to illuminate Kahneman's two systems of thinking in psychotherapy practice. Rober (2020) explains how on first meeting a young girl and her family, referred for psychotherapy because for her experience of abuse, he performs an unplanned action which surprised him, in two ways. Firstly, in undertaking the action (getting to his knees and engaging her directly in conversation) and secondly, in its good therapeutic effect. Reflecting upon this Rober, says:

> "In retrospect what I did was strange and puzzling (……). In retrospect, I can see I proceeded step by step, not guided by some sort of pre-conceived mental plan or protocol, but by the immediate responses my steps evoked.." (page 8).

In Kahneman's terms his system 2 was in watchful mode whilst intuitive system 1 was 'leading the way' (Rober, 2020).

An example closer to A&S MHN contexts was presented at a recent (Newcastle, 2023) conference: Alexis (see footnote) reported that due to her perceived risk whilst being transferred between NHS secure units she was hand and leg cuffed and locked in a metal cage in the back of an ambulance. On arriving she was let out to see two lines of nurses

looking tense and prepared for action when a ward sister she knew, approached. The Sister said ‘take her cuffs off’ - repeating this very firmly to the staff when no one responded. On removal of the cuffs Alexis reports that the nurse hugged her tightly and told her, "you're safe now... everything will be ok". Whilst that hug by the MHN would not have been in any protocol or best practice guidance – it would be questioned by some as a breach of professional boundaries and was certainly unplanned - it might be best understood as the ultimate intuitive response to observed distress. It also represented effective MHN practice.

Alternative presentations to Kahneman’s (2011) of intuition and intuitive expertise are available. Such as, Conlon et al. (2023) present Cognitive Continuum Theory (CCT) as a way for MHN to understand their complex roles. CCT premises two poles on a continuum of: intuitive to analytical thinking, including using all accessible and unknown environmental cues effortlessly and flexibly, whilst oscillating between the poles blending intuition and analysis during decision making (Conlon et al., 2023).

Table 2, incorporating Jackson and Stevenson’s framework of ordinary me and professional me along with the two systems of thinking suggests that examining the impact of intuitive and analytical thinking may apply fruitfully too many questions for MHN that need to be addressed. Such as: Is movement along the spectrum/continuum achieved effortlessly, intuitively or does it require conscious effort and practice? Can intuition be trusted? Is it possible to create conditions e.g. training that speed up the development of reliable intuitive expertise?

Kahneman (2011) and Conlon et al., (2023) presentations of intuition and conscious analysis above suggest rather different approaches to these sort of questions; which would be a useful avenue for future analysis. Conlon et al. (2023) and Kahneman (2011) agree that

experience and practice within a certain role leads to more accurate relevant intuitions. (Footnote: Alexis who experienced a prolonged period of mental health care is now the manager of the Reducing Restraint Network in the UK.)

They differ on aspects of the interaction between intuition and conscious analytical thinking. CCT suggests that movement along the continuum from intuition to analysis occurs effortlessly, people respond to environmental cues to achieve the best mix of analysis and intuition, to inform decision making, including for MHN engagement. Whilst Kahneman's (2011) focus is largely upon the flaws of biased and heuristic intuitive thinking, when effortful conscious thinking would be better employed, but often isn't:

> *"There is no simple way for System 2 to distinguish between a skilled and a heuristic response. Its only recourse is too slow down (…..) which it is reluctant to do because it is indolent" (p 416/17).*

Kahneman (2011) says that for intuitive expertise to develop depends upon:

> "*a regular environment, an adequate opportunity to practice, and rapid and unequivocal feedback about the correctness of thoughts and actions." (p 414)*

One intervention intended to provide a regular environment to promote therapeutic MHN engagement with people receiving A&S care is 'protected engagement time' (PET) (McCrae, 2014; McAllister et al., 2021b). PET, a national, top down policy driven intervention in the UK, was later introduced within Sweden as 'Time to Talk' and Time together' (Molin et al., 2020; Reinius et al., 2022, respectively). Early evaluations of PET have shown that MHN are often unable to overcome organisational and personal barriers to using PET for constructive engagement (McCrae, 2014). Later PET evaluations found that greater

structure, including feedback and influence over the sessions by people receiving A&S care, and skilled facilitation achieved better results (McAllister et al., 2021b: Molin et al., 2020; Reinius et al., 2023; Taylor et al., 2022).

Little MHN research has focused upon the second of Kahneman's conditions for developing intuitive expertise - the provision of immediate and unequivocal feedback. It is likely that most feedback experienced by MHN to engagement is delayed (e.g. Taylor et al., 2022), or as in reflective practice, whether guided in group sessions or individual. Immediate feedback is only likely to be experienced from people experiencing severe mental ill-health, which may impede its reliability (McAllister et al., 2021b) or from peers who may be opposed, or uneasy about implementation of PET and other similar interventions (McCrae, 2014; Taylor et al., 2022; McAllister et al., 2021b; Molin et al., 2020).

The provision of managerial and practitioner support for PET or other interventions to improve MHN engagement with people receiving A&S care may benefit from a style of frontline support called *practice leadership* to demonstrate skilled practice and provide immediate feedback (see Deveau & McGill, 2016; Deveau et al., 2020).

Conclusions

MHN regard the therapeutic relationship with people experiencing severe mental ill-health as core to their role and practice. However, therapeutic engagement is often not experienced by people in A&S care and MHN have difficulty explaining this aspect of their role to others and themselves. People receiving A&S care report engagements focused upon everyday ordinary interactions and activities as therapeutic but such everyday ordinariness like the MHN therapeutic role remains 'strangely illusive'. This paper suggests that Daniel

Kahneman's work on the two systems of thinking is applicable to understanding MHN engagement and presents an analysis rooted in daily experience, how our worlds are perceived and reacted to. Thus providing ways to explain and improve MHN practice. In specific ways such as changing the information regarding people in A&S care to be more person centred and, more broadly, for understanding and explaining the MHN role and practice for therapeutic engagement. According to Kahneman with planned guidance, sufficient practice and immediate feedback, conscious effortful thinking for MHN can impose desirable thinking and behaviours. And with practice these can be adopted as routine ordinary (effortless, intuitive) experiences and ways of behaving. Eventually to be experienced as skilled intuitive expertise.

This position paper is intended to stimulate interest, further analysis and research into a range of possible areas suggested by Daniel Kahneman's work. Such as, what are the areas of agreement and disagreement between various conceptualisations of intuition and intuitive expertise for MHN? Can Kahneman's concept of the development of intuitive expertise be implemented and assessed within A&S care? Lastly, that Kahneman's two systems of thinking will support equal regard for largely intuitive everyday engagement and consciously delivered therapy. It may also provide MHN with the knowledge and confidence to take interventions like PET into their hearts and minds with energy and commitment.

Relevance to clinical practice

This initial exploration of Daniel Kahneman's work suggests many areas for beneficial developments in mental health nursing, including:

- a scientific perspective i.e. neuroscience for therapeutic engagement which includes ordinary social dialogue as of equal importance to structured therapy, PET is as important as therapy;
- Developing engagement skills for critical, challenging situations requires opportunities to practice with immediate feedback. This feedback will be provided either by skilled MHN or immediate informal staff cultures – this is a challenge and should be a choice, not left to chance, in A&S care;
- Confirmation bias and 'priming' suggest potentially strong positive impacts from what appear, and should be, easy interventions.

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