PSYCHOLOGICAL ASPECTS
OF PSYCHIATRIC HOSPITALISATION

VOLUME I: RESEARCH COMPONENT

BY

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OVERVIEW

Volume I

Volume one contains a literature review examining the literature on the psychological impact of seclusion on service users, and a qualitative research project investigating the experiential impact of caring for individuals with early psychosis on inpatient nursing staff. This is followed by a public domain briefing paper which summarises both the literature review and research paper.

The literature review evaluated the findings of international research studies which focused on service user perspectives of seclusion. Eight common themes were identified; the emotional impact of seclusion, seclusion as an experience of punishment, seclusion as an experience of being controlled, seclusion as a dehumanising experience, seclusion as a traumatic experience, the effect of seclusion on staff-patient relationships, positive effects of seclusion, and coping with seclusion. Although some studies reported positive aspects of seclusion, the overall results of the review suggest that seclusion has a negative psychological impact on service users. Recommendations for minimising the negative psychological impact of seclusion on service users are discussed.

The empirical paper investigated the experience of inpatient nursing staff of working with hospitalised patients with early psychosis, through semi-structured interviews. Interview transcripts were analysed using Interpretative Phenomenological Analysis. Five main themes emerged from this analysis; 1) Working with uncertainty, 2) Feeling restricted, 3) The ward as a threatening environment, 4) “You’re like my bloody mother” - Working with younger patients, and 5) “Shut the doors and go home” - Coping and self-preservation. These themes are discussed along with implications for practice and further research.

Volume II

Volume II contains five Clinical practice reports:

Clinical Practice Report 1 describes a 34 year old woman referred to Psychology within a CMHT with low self esteem. Cognitive and psychodynamic formulations of her difficulties are presented, followed by a critical appraisal of the two models.

Clinical Practice Report 2 is a single-case experimental design study of a cognitive behavioural therapy intervention with a 34 year old man referred to Psychology within a CMHT with a diagnosis of Body Dysmorphic Disorder.

Clinical Practice Report 3 is a small-scale service evaluation of the views of staff working in a city wide specialist learning disabilities service regarding the use of person stories to obtain service user views on the service.

Clinical Practice Report 4 presents a case study of a cognitive behavioural intervention with an 11 year old boy referred to CAMHS Psychology with obsessions and compulsions relating to Tourette Syndrome.

Clinical Practice Report 5 was an oral presentation of a case study of ongoing psychodynamic psychotherapy with a 34 year old woman referred to a specialist psychodynamic psychotherapy service, following a breakdown and significant deterioration of functioning. The aim of therapy was to explore deep-rooted issues around relationships and her sense of self, related to having been adopted.

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ABSTRACT

Seclusion is used in acute psychiatric inpatient settings in response to violent or disruptive behaviour. It is recommended in national guidelines despite a lack of evidence for its effectiveness. The available literature on service user perspectives on the use of seclusion was last reviewed in 1995. The purpose of the current review was to examine the literature published since 1995 on service user perspectives on seclusion, to explore the psychological impact of being secluded. Thirteen studies were identified, and the quality of these studies was evaluated. The findings of the studies were examined and eight common themes were identified; the emotional impact of seclusion, seclusion as an experience of punishment, seclusion as an experience of being controlled, seclusion as a dehumanising experience, seclusion as a traumatic experience, the effect of seclusion on staff-patient relationships, positive effects of seclusion, and coping with seclusion. Although some service users reported some positive aspects of seclusion, the overall consensus is that seclusion is a distressing experience. This review suggests additional recommendations to those in the existing guidance which may reduce the negative psychological impact of seclusion on service users, for example, more effective communication, increased contact with staff, and follow-up support. Further research is needed to consider the psychological impact of seclusion use in the UK.

INTRODUCTION

Seclusion is used with service users in acute psychiatric inpatient settings as a method of physical containment in response to violent or disruptive behaviour. It is defined as “the supervised confinement of a patient alone in a room, the essence being the involuntary isolation of the patient” (Royal College of Psychiatrists, 1995). One of the best indicators of the scale of seclusion use is provided by a multivariate cross-sectional study of 136 psychiatric wards in England by Bowers, Whittington, Nolan, Parkin and Curtis (2006). This study found that 28% of patients had undergone seclusion, that 46% of staff had used seclusion, and that the estimated annual cost of seclusion in the UK is almost £2 million. Despite the prevalence of the use of seclusion, a recent systematic review of the safety and effectiveness of seclusion resulted in the conclusion that the evidence available is not sufficient to determine whether seclusion is a safe or effective intervention (Nelstrop et al., 2006). A Cochrane review of the effects of seclusion and restraint (Salias & Fenton, 2000) found that no studies met the minimum inclusion criteria, as there were no existing controlled studies evaluating the value of using seclusion or restraint in inpatient mental health settings, and therefore no recommendations for its effectiveness, benefits or harmfulness could be made. We must note the difficulty in designing a study which would meet Cochrane criteria for this topic, given that assessing the outcomes of seclusion may be difficult. Fisher’s (1994) qualitative review suggests that seclusion and restraint can lead to adverse physical and psychological effects on both staff and patients, and concludes that the use of seclusion should be minimised for ethical reasons.

The NICE guidelines on the short-term management of disturbed/ violent behaviour in inpatient psychiatric settings (2005) state that seclusion should be used as a management strategy, but not as a therapeutic intervention, and as a last resort to avoid prolonged physical intervention. However the guidelines also state that, because there is a lack of evidence for the effectiveness of seclusion, caution is required in its use. A definition of the 'effectiveness' of seclusion is not given in the guidelines. In their recent systematic review of the effectiveness of seclusion, Nelstrop et al. (2006) stated that seclusion's "sole aim is to contain severely disturbed behaviour that is likely to cause harm to others" (p.18). However, the available literature did not offer any generalisable criteria for the measurement of the effectiveness or the safety of seclusion. Two studies in the review suggested that the use of seclusion rooms leads to a reduction in violent incidents. However another study suggested that violence is reduced by other factors such as staffing levels and education. Nelstrop et al. (2006) concluded that there is not sufficient evidence to determine whether seclusion is effective.

Service user perspectives on seclusion

The 'service user perspectives' on the use of seclusion in the NICE guidelines (2005) are actually drawn from an earlier review carried out in 1995 which aimed to inform clinical practice in 'the management of imminent violence in mental health services' (Royal College of Psychiatrists, 1998). This review of 16 relevant documents on both physical restraint and seclusion, seven of which included service user views on the use of seclusion (Binder & McCoy, 1983; Soliday, 1985; Hammill, McEvoy, Koral, & Schneider, 1986; Wise, Mann, Murray, & Lopez, 1988; Tooke & Brown, 1992; Kennedy, Williams & Pesut, 1994; and Eriksson & Westrin, 1995), resulted in the conclusion that no conclusions could be drawn from the evidence. The Royal College of Psychiatrists' (1998) guidelines suggest that surveys of service user attitudes tend to provide conflicting results, which reflect problems with methodology. It was noted however that the comments of service users suggest that "there is a 'grey area' between coercion and voluntary acceptance of care" (p. 37). The resulting guidelines for the use of seclusion in this document suggest that seclusion is only justified as a last resort, and should be carried out for the shortest period possible. It is also stated that the reasons for seclusion should be explained to the service user as far as possible, and that staff should specify the likely outcome and repeat the explanation afterwards. Regarding the effects of seclusion on the service user, it was stated in the protocol for the use of seclusion that “service users generally dislike seclusion, even when it is carried out properly, but some accept that it can be necessary and that it need not affect the outcome of treatment” (p. 62). The NICE guidelines (2005) did not include an updated review of service user perspectives on seclusion, but rather cited the Royal College of Psychiatrists' (1998) review. The resulting evidence statement in the NICE guidelines states that “The limited evidence suggests that service users may find seclusion and restraint degrading, although some service users believe that measures, such as seclusion and physical intervention, are sometimes justified” (p. 69).

Rationale for the current review

A literature search suggested that no reviews of the literature on the impact of seclusion on mental health service users have been carried out since 1995. Of the seven articles on service user perspectives on seclusion reviewed by the Royal College of Psychiatrists in 1995, four were from the USA, and the remaining three were from Canada, Sweden and the UK. The definitions and methods of seclusion may differ between countries, and relatively little research has been carried out into service user perceptions of seclusion in the UK. The guidelines for the use of seclusion in the UK have been based on international research, and so the further 13 studies which have been carried out internationally since 1995 investigating the impact of seclusion on adult service users in psychiatric inpatient care will be reviewed here.

METHOD

A literature search was conducted using the databases PSYCINFO and MEDLINE for articles published between 1996 and 2010. The search terms used were: [seclu*] AND [(patient*) OR (client*) OR (service user*)] AND [(view*) OR (perception*) OR (attitude*) OR (satisfaction) OR (perspective*) OR (experience*)], where * indicates that words with any ending to the given prefix are searched for. The search yielded 236 results after duplicates were removed. The abstracts of these articles were studied to determine suitability. Twenty-two articles were excluded because they were not written in the English language, nine were excluded because they were not peer reviewed journal articles (e.g. book chapters or dissertation abstracts), 67 were excluded because the topic under investigation was not seclusion, but service user perspectives on unrelated interventions. Eighteen were excluded because they researched the seclusion of children, people with learning disabilities or older people. 73 were excluded because their focus was on aspects of seclusion other than user perspectives (such as history of use, frequency of use, guidelines for use, reduction of use and effectiveness) and 34 were excluded because they investigated staff views but not service user perspectives on the use of seclusion. The remaining 13 studies were included in the review. The reference lists of these articles were reviewed in order to find any additional studies not identified in the search, but no further studies were identified.

RESULTS

Characteristics of studies

A summary of the main characteristics of the studies can be found in Table 1. Of the 13 studies included in the review, three were conducted in Australia (Meehan, Bergen, & Fjeldsoe, 2004; Meehan, Vermeer, & Windsor, 2000; Roberts, Crompton, Milligan, & Groves, 2009), three were from The Netherlands (Stolker, Nijman, & Zwanikken, 2006; Veltkamp, Nijman, Stolker, Frigge, Dries, & Bowers, 2008; Hoekstra, Lendermeijer, & Jansen, 2004), two were from the USA (Ray & Myers, 1996; Martinez, Grimm, & Adamson, 1999), one was conducted in Germany (Steinert, Bergbauer, Schmid, & Gebhardt, 2007), one was from Finland (Keski-Valkama, Koivisto, Eronen, & Kaltiala-Heino, 2010), one was from Canada (Holmes, Kennedy, & Perron, 2004), one was conducted in South Africa (Mayers, Keet, Winkler, & Flisher, 2010) and one was from New Zealand (El-Badri & Mellsop, 2008).

All of the reviewed studies were conducted in inpatient psychiatric settings, and participants in all of the studies were either current inpatient service users or former inpatients. The time elapsed between being in seclusion and the point of data collection varied greatly between studies, ranging from within 24 hours to within 12 months. Some studies investigated both staff and service user perspectives on seclusion, and some studies investigated service user perspectives on both seclusion and physical restraint. One study compared forensic and general psychiatric service user views on seclusion. Details of the method of seclusion, duration of seclusion, time since seclusion, amount of staff contact during seclusion, or the conditions of the seclusion room were not always provided. Six of the thirteen studies utilized quantitative methods, four used qualitative methodology and three studies applied a mix of both quantitative and qualitative methods.

Table 1: Summary table of studies published since 1995 on service user perspectives of seclusion.

Quantitative Studies

Authors/ Date	Country	Title	Sample	Design/ Measures/ Analysis	Main Findings
Ray & Myers (1996)	USA	Patient perspectives on restraint & seclusion experiences: A survey of former patients of New York state psychiatric facilities	1040 former psychiatric patients – 560 were restrained or secluded "sometime in the past"	Mail questionnaire/ survey designed by authors/ descriptive statistics	Restraint/seclusion associated with negative assessment of overall hospital stay. Seclusion punitive, unnecessary, premature, inhumane conditions, poor standard of care. Less negative report if believed staff tried less restrictive interventions.
Meehan, Bergen & Fjeldsoe (2004)	Australia	Staff and patient perceptions of seclusion: has anything changed?	60 Nurses.29 patients. Time since seclusion 14 days – 12 months. Seclusion duration average 2.4 hours.	Questionnaire/ Heyman's (1987) Attitudes Toward Seclusion Survey/ Chi Square tests	Significantly more nurses attributed positive effects than patients. Patients see seclusion as a form of punishment, of little therapeutic value, means of nurses exerting power & control.
Stolker, Nijman & Zwanikken (2006)	The Netherlands	Are patients' views on seclusion associated with lack of privacy in the ward?	54 patients within 1 week of seclusion (most within 24 hrs). Duration range 1-1,381 hrs (median 37h). Some allowed to leave the seclusion room for up to 6 hrs.	Questionnaire/ Patient view of seclusion questionnaire (Hammill et al, 1989)/ t-tests & Pearson's *r*	Significant association between less negative view of seclusion and having resided in a multiple bed room with fellow patients prior to being secluded. Lack of privacy on the ward makes seclusion more attractive?
Steinert, Bergbauer, Schmid & Gerbhardt (2007)	Germany	Seclusion and restraint in patients with schizophrenia: clinical and biographical correlates	117 consecutive admissions with diagnosis of schizophrenia (42 secluded or restrained)	Interview, questionnaires, demographic & treatment related data/ PANSS, GAF, PDS (post traumatic diagnostic scale)/ Logistic regression models	Lifetime history of trauma significantly associated with lifetime occurrence of seclusion or restraint → enhanced risk of re-victimisation & re-traumatisation
Veltkamp, Nijman, Stolker, Frigge, Dries & Bowers (2008)	The Netherlands	Patients' preferences for seclusion or forced medication in acute psychiatric emergency in the Netherlands	104 patients – 49 secluded, 3 medicated, 43 both. Participated in final 2 weeks of hospital stay.	Questionnaire designed for study, visual analogue scales for aversiveness and efficacy of seclusion and forced medication/ Chi square tests, t-tests & ANOVA	Feeling alone & locked in, rest, security, sleep. Equal numbers preferred seclusion and medication.

Keski-Valkama, Koivisto, Eronen & Kaltiala-Heino (2010)	Finland	Forensic and general psychiatric patients' views of seclusion: a comparison study	106 secluded patients. Surveyed 'shortly after' seclusion (0-47 days) and 6 months later. Duration of seclusion range 5.6 hrs – 463.1 days (median38.5h).	Structured interview developed for study/ Mann-Whitney U, Chi-square, The McNemar test	Negative effect on psychiatric condition, ostracised, negative attitude to treatment, fear of re-seclusion. Insufficient interaction with staff. Forensic patients viewed seclusion as punishment more frequently.

Qualitative Studies

Authors/ Date	Country	Title	Sample	Design/ Measures/ Analysis	Main Findings
Meehan, Vermeer & Windsor (2000)	Australia	Patients' perceptions of seclusion: a qualitative investigation	12 patients, seclusion within 7 days prior to interview. Average duration of seclusion 3.4 hrs	Semi-structured interview/ Thematically organised interview schedule/ Content analysis	5 major themes: Use of seclusion, Emotional Impact (anger, powerlessness, humiliation, helplessness, disempowering, fear), Sensory deprivation, Maintaining control, Staff-patient interaction. Positive effects: calming, protection, feeling safe.
Hoekstra, Lendemeijer & Jansen (2004)	The Netherlands	Seclusion: the inside story	7 patients, secluded 'some time ago' – outpatients at time of interview	Semi-structured Interviews/ Grounded theory	Central themes: Autonomy (dependence, powerlessness, humiliation, being watched, shame, loss) Trust (fear, suspicion, insecurity, oppression, distrust, arbitrariness, safety, acceptance) Loneliness (being alone, boredom)
Holmes, Kennedy & Perron (2004)	Canada	The mentally ill and social exclusion: a critical examination of seclusion from the patient's perspective	6 patients – secluded less than 7 days prior to interview	Semi-structured interview/ Content analysis	3 main themes: emotional experience, perception of seclusion and coping. Punitive measure, modality for social control, intensification of already existing feelings of exclusion, rejection, abandonment & isolation. Coping: acting out or compliance.
Mayers, Keet, Winkler & Flisher (2010)	South Africa	Mental Health Service User's perceptions & experiences of sedation, seclusion and restraint	2 focus groups – 8 patients in each. Questionnaire interview – 43 patients	Focus groups and Semi-structured questionnaire interview/ Thematic analysis	Themes: Inadequate communication, Violation of rights, Experience of distress.

Mixed Methods Studies

Authors/ Date	Country	Title	Sample	Design/ Measures/ Analysis	Main Findings
Martinez, Grimm & Adamson (1999)	USA	From the other side of the door: patient views of seclusion	69 patients. 53 secluded patients (9 children, 8 adolescents, 36 adults)	Brief written survey and focus group discussion/ Descriptive statistics on survey data, Content analysis on verbal comments from discussion	Patients viewed seclusion as a form of punishment – effect on therapeutic relationships. Power differences-potential for abuse.
El-Badri & Mellsop (2008)	New Zealand	Patient and staff perspectives on the use of seclusion	111 patients (56 secluded), 138 staff.	Questionnaire designed for study/ Descriptive statistics, Content analysis of qualitative data	Quantitative: seclusion negative, distressing, neglected, powerless, worthless. Qualitative: emotional impact: fear, anxiety, punished, lonely, powerless, angry, abused or inhumanely treated. Positive: safety of self & others, calming, low stimulus.
Roberts, Crompton, Milligan & Groves (2009)	Australia	Reflections on the use of seclusion	4 patients, 71 staff. Focus group – 8 patients	Retrospective chart reviews, qualitative survey data, focus groups/ Attitudes to seclusion survey (Heyman 1987)/ Descriptive statistics, Survey responses & focus group discussions thematically analysed.	Patients perceived exclusion as punishing and non-therapeutic. Experience traumatic, trapped & insecure, feeling alienated, mistrust, anger.

Critical appraisal of the evidence

The methodological quality of the studies included in the review was evaluated using the criteria proposed by Sale and Brazil (2004) for critically appraising quantitative, qualitative and mixed method studies. Each of these criteria includes a goal for both qualitative and quantitative methods, for example the ‘truth value’ refers to the ‘credibility’ of qualitative methods (such as triangulation) and also the ‘internal validity’ of the quantitative methods (such as controlling for extraneous or confounding variables). The evaluation of the methodology of the reviewed studies using these criteria is detailed in Appendix I. Each study was scored according to the number of goals met. The order of studies according to their level of adherence to the criteria can be found in Table 2.

Table 2: Studies in descending order of adherence to Sale and Brazil's (2004) quality criteria.

Order	Study	Quantitative/ Qualitative/ Mixed	% of criteria met
1	**Keski-Valkama, Koivisto, Eronen, & Kaltiala-Heino (2010)**	Quantitative	61%
1	**Steinert, Bergbauer, Schmid, & Gebhardt (2007)**	Quantitative	61%
1	**Stolker, Nijman, & Zwanikken (2006)**	Quantitative	61%
4	**Hoekstra, Lendermeijer, & Jansen (2004)**	Qualitative	59%
4	**Holmes, Kennedy, & Perron (2004)**	Qualitative	59%
6	**Meehan, Bergen, & Fjeldsoe (2004)**	Quantitative	58%
7	**Mayers, Keet, Winkler, & Flisher (2010)**	Qualitative	47%
7	**Meehan, Vermeer, & Windsor (2000)**	Qualitative	47%
9	**Ray & Myers (1996)**	Quantitative	45%
9	**Veltkamp, Nijman, Stolker, Frigge, Dries, & Bowers (2008)**	Quantitative	45%
11	**Martinez, Grimm, & Adamson (1999)**	Mixed	40%
12	**El-Badri & Mellsop (2008)**	Mixed	31%
13	**Roberts, Crompton, Milligan, & Groves (2009)**	Mixed	28%

On examining Table 1 it appears that the papers which met the quality criteria to a greater extent were a mixture of qualitative and quantitative studies, and the studies which met the criteria to a lesser degree used mixed methodologies. It may be the case that these studies employed more strategies to ensure methodological rigour than were reported due to word limits; the current evaluation of methodology relied on these being reported in the articles.

The purpose of this review was to summarise the available recent literature on the psychological impact of seclusion on service users. In order to do this the findings of the studies were examined and common themes were identified. The results presented here are categorised into eight themes; the emotional impact of seclusion, seclusion as an experience of punishment, seclusion as an experience of being controlled, seclusion as a dehumanising experience, seclusion as a traumatic experience, the effect of seclusion on staff-service user relationships, positive effects of seclusion, and coping with seclusion.

The emotional impact of seclusion

Most of the studies reviewed commented on the emotional impact of seclusion on service users. In the qualitative information gathered in their purpose-designed questionnaire, El-Badri and Mellsop (2008) found that fear and anxiety were the most prevalent emotions reported. Martinez et al. (1999) reported that 63.8% of surveyed participants felt fearful when in seclusion, however their study included children and adolescents as well as adult participants. In a grounded theory analysis of qualitative interview data, Hoekstra et al. (2004) found themes of fear, suspicion, insecurity and distrust. Meehan et al. (2000) found that fear was not easily reduced on release from seclusion, and Mayers et al. (2010) found that observing other service users being secluded on the ward caused further distress and fear of re-hospitalisation.

Although seclusion is often utilised in response to violent behaviour, a number of studies reported that anger was a consequence of being secluded. Content analysis of qualitative interviews by Holmes et al. (2004) showed that service users reported anger due to being locked up or due to a perceived lack of care from staff whilst in the seclusion room, and that they expressed this anger through violent behaviours towards objects in the room or verbally abusing staff. In another content analysis of qualitative interviews, service users reported feelings of anger before, during and after seclusion, which was directed primarily at the staff involved in their seclusion. The source of anger was reported as a perception that there was no opportunity for them to defend or discuss their actions before being secluded (Meehan et al., 2000). In the study by Roberts et al. (2009) focus group and survey participants reported that their seclusion experiences left them feeling angered and annoyed. El-Badri and Mellsop (2008) found that secluded service users, non-secluded service users and staff all agreed that secluded service users were “stressed out as opposed to relieved” (p. 249). In another study, participants reported that anger and agitation were the first emotions experienced when entering seclusion, due to conflicts preceding seclusion, their treatment when being secluded, and a feeling of being ‘tricked’ (Martinez et al., 1999).

Emotions associated with loneliness were reported by service users in some studies; Veltkamp et al. (2008) reported that the most common negative aspect of seclusion reported by service users was feeling alone and locked in. Holmes et al. (2004) found that participants reported sadness and depressive feelings due to being left alone in the seclusion room with little or no contact, and therefore feeling abandoned. In the study by Roberts et al. (2009), patients described feeling trapped, insecure, frightened and alone, whilst participants in another study described feelings of humiliation, shame, loneliness and boredom (Hoekstra et al., 2004).

Some studies reported that the emotional impact of seclusion has consequences for the overall psychological wellbeing of the service user; the experience of seclusion and the fear of re-seclusion are suggested to have a negative effect on the service user’s psychiatric symptoms and condition (Keski-Valkama et al., 2010; El-Badri & Mellsop, 2008).

Seclusion as an experience of punishment

In more than half of the studies reviewed, seclusion was experienced by service users as a form of punishment. Seclusion is described by some service users as a punitive measure (Holmes et al., 2004) and as punitive and unnecessary (Ray & Myers, 1996). Mayers et al.

(2010) reported that 78% of their respondents viewed seclusion as punishment. In structured interviews conducted by Keski-Valkama et al. (2010), 66.3% of service users perceived seclusion as a form of punishment; 42.1% of these participants felt they were secluded as a consequence of bad behaviour, and 18.4% felt the reason for seclusion was either unknown or insignificant, however these results were reported by a combination of general psychiatric and forensic service users, some of whom were secluded for extremely long periods of time. In other studies, participants viewed seclusion as a form of punishment, and therefore of no therapeutic value (Meehan et al., 2004; Mayers et al., 2010; Roberts et al., 2009). Martinez et al. (1999) reported that 76.5% of participants surveyed felt punished, and stated that "Many patients viewed seclusion as a form of punishment because the isolating effects were just the opposite of what the patients wanted or believed they needed at the time" (p.19). Some service users believed that seclusion was used as retribution for not complying with treatment or not following the instructions of staff (Roberts et al., 2009; Ray & Myers, 1996). Some service users believed that they were being placed in confinement because they were being punished for being 'bad', and that their perceptions of being neglected and degraded reinforced this belief (Holmes et al., 2004). Participants in the study by Meehan et al. (2000) felt that they had not been fully informed of ward rules and this meant that their seclusion was more likely. These authors noted that the association between seclusion and punishment related to the use of force and the experience of the seclusion room being described by five respondents as "equivalent to a prison, jail, lock-up or watch house" (p. 373).

Seclusion as an experience of being controlled

Seclusion is described by service users in some studies as a means of staff maintaining physical and psychological control over them; some participants in Martinez et al.'s (1999) study perceived that they were told what to think or were forced to agree with staff before being allowed to exit seclusion, and 54.3% of participants felt a loss of control when in seclusion. Seclusion was also perceived by some as a modality for social control (Holmes et al., 2004). Hoekstra et al. (2004) reported that some participants' experiences related to the theme of the loss of autonomy; increased dependence, powerlessness, humiliation and the feeling of being watched, and related this to "the experience of the absolute power of nurses" (p. 279). Most (85%) of the participants in Meehan et al.'s (2004) study reported a perception that staff enjoyed a sense of power and retribution when secluding service users, and El-Badri and Mellsop (2008) reported that service users felt controlled especially if they believed their seclusion was not necessary or deserved.

Seclusion as a dehumanising experience

Conditions of seclusion rooms

Being secluded can lead to sensory deprivation; this was described by participants as a heightened awareness of sounds, difficulty in judging time, dysfunctional thought patterns, a fear that they were 'going mad', perceptual disturbances, hypersensitivity and hallucinations, and this description was likened to those of prison inmates in solitary confinement (Meehan et al., 2000). Participants in another study described their seclusion room experience as cold, hard and smelly, and commented on a lack of privacy (Martinez et al., 1999). Negative comments about the set-up of seclusion rooms reported by El-Badri and Mellsop (2008) included that service users felt uncomfortable, claustrophobic, cold and bored. Meehan et al. (2000) reported that participants felt that boredom and under-stimulation was a source of stress. Keski-Valkama et al. (2010) reported that service users felt the setting of the seclusion room was inhumane, and led to them feeling stigmatised and ostracised.

Standard of care

Ray and Myers (1996) reported that 78% of the service users surveyed reported that the care they received when in seclusion was not compliant with at least one standard in the state regulations; 58% reported that they were not released every two hours, 46% were not allowed to use the bathroom hourly, 38% were not checked by staff every 30 minutes, and 34% reported that they were not allowed to drink or eat at mealtimes. This study however investigated both seclusion and physical restraint, and responses about each containment method were not differentiated from each other. El-Badri and Mellsop (2008) found that some service users felt abused or inhumanely treated and experienced a loss of dignity. Some participants reported experiences, such as having to undress in front of staff, which left them feeling degraded, ashamed and humiliated (Holmes et al., 2004). In this same study participants reported a perceived lack of concern for their welfare and basic needs. Meehan et al. (2000) also reported that service users experienced disempowerment in the form of humiliation, with the stripping away of identity, clothes and personal property. Mayers et al. (2010) reported that it was clear from the accounts of service users that they had experienced an infringement of their human rights, inhumane treatment and a lack of respect for human dignity.

Seclusion as a Traumatic Experience

Re-traumatisation

Some service users described their seclusion experience as traumatic (Roberts et al., 2009). 40% of respondents surveyed by Ray and Myers (1996) believed that they had been “psychologically abused, ridiculed or threatened” (p. 7). Seclusion may cause re-experienced trauma; Steinert et al. (2007) found that service users with a lifetime history of trauma had a significantly higher likelihood of lifetime occurrence of seclusion or restraint.

They concluded that, as well as seclusion being a traumatic event in itself, a history of trauma enhances the risk of re-traumatisation and re-victimisation during psychiatric hospitalisation; however it was acknowledged in this study that, although there is an association between seclusion or restraint and a history of traumatic events, it is uncertain which occurred first. Participants in Holmes et al.'s (2004) study felt that their experience of seclusion lead to an escalation of already existing feelings of exclusion, rejection, abandonment and isolation, and that during the seclusion process the behaviour of staff may re-enact the behaviour of important people in the service users' lives; "Seclusion appeared to act as a catalyst in reawakening and intensifying already existing feelings of being alone and abandoned by significant others" (p570). El-Badri and Mellsop (2008) suggested that the sadness, misery, rejection, betrayal, guilt, and embarrassment experienced by service users in seclusion may remind them of previous abuse.

Lasting effects

In Ray and Myers' (1996) study, seclusion was remembered as a distinctly negative experience after discharge from hospital. In another study, participants reported a fear of re-seclusion, and the majority of participants interviewed at six month follow up maintained their original view of seclusion as a negative and punishing experience (Keski-Valkama et al., 2010). Hoekstra et al. (2004) suggest that we tend to justify traumatic events in retrospect in order to aid acceptance, and therefore coming to terms with being secluded is helped by the passing of time. This may explain the fact that participants in this study did not report many experiences of anger about being secluded, possibly due to the interviews taking place "a long time" after the seclusion experience. However, the majority of participants reported that they have not come to terms with the seclusion experience and reported feeling "insecure in subsequent situations" (p.280). Lasting effects of being secluded are described by some participants in this study as a fear of enclosed spaces, a lack of trust, and a fear of being harmed (Hoekstra et al., 2004). Being secluded was found in one study to be significantly associated with a more negative assessment of the overall inpatient stay (Ray & Myers, 1996).

The Effect of Seclusion on Staff-Patient Relationships

Contact with staff during seclusion

Participants in many of the studies commented on a lack of contact with staff during seclusion (Hoekstra et al., 2004; Holmes et al., 2004; Keski-Valkama et al., 2010; Ray & Myers, 1996; El-Badri & Mellsop, 2008; Mayers et al., 2010; Meehan et al., 2000; Martinez et al., 1999). Some participants felt that staff were keeping them at a distance (Holmes et al., 2004), and suggested that, rather than seclusion itself, it was the lack of nurse contact that impacted on their negative perception and emotional experience and reinforced the idea that they were being punished and abandoned. Meehan et al. (2000) reported that participants expressed a need for more interaction between staff and patients during seclusion. El-Badri and Mellsop (2008) reported that participants wished there had been a member of staff to talk to during the seclusion experience, and that the lack of company and support made the experience worse.

Communication and explanation before, during and after seclusion

The literature suggests a need for greater communication between nurses and patients (Meehan et al., 2004) and that participants express a need for more effective communication, support and debriefing (Meehan et al., 2000). Ray and Myers (1996) found that 42% of participants believed that staff had tried less restrictive interventions before using seclusion, which was significantly associated with less negative reports of the seclusion experience, but 47% felt that staff had not tried other methods first. Roberts et al. (2009) reported that service users were unaware of the reasons for their seclusion, which led to feelings of bewilderment and a mistrust of staff, and poor communication from staff left them feeling frustrated and alienated. El-Badri and Mellsop (2008) found that some participants felt they did not receive any explanation of the seclusion procedure, the reason for being secluded or on what basis the decision to release them would be made. Mayers et al. (2010) reported that service users received no explanation or alternative options, and less than 20% of participants were de-briefed or re-orientated to the ward; however this study refers not only to seclusion but to restraint and sedation also. Ninety percent of general psychiatric hospital service users in the study by Keski-Valkama et al. (2010) reported that no debriefing had been performed following seclusion, and the authors commented on the possible negative effects of this on the therapeutic relationship between service users and staff.

Impact on therapeutic relationships

The experience of negative emotions, a perception of being punished, controlled and dehumanised, and a perceived lack of communication as a consequence of being secluded would be expected to have a negative effect on therapeutic relationships. El-Badri and Mellsop (2008) concluded that the therapeutic relationships between staff and service users would be affected by participants being left feeling betrayed and embarrassed by their seclusion experiences. Another factor which may impact therapeutic relationships is the differing views of service users and staff about seclusion. Three of the studies reviewed investigated both staff and service user views on seclusion (Meehan et al., 2004; El-Badri & Mellsop, 2008; Roberts et al., 2009), and all three reported a discrepancy between staff and service user attitudes to seclusion. Meehan et al. (2004) found that 93% of nurses felt that service users would feel better due to seclusion, and only 35% of service users believed that seclusion made them feel better. El-Badri and Mellsop (2008) reported that, although staff and patients agreed that the experience of seclusion was distressing, 61% of patients felt that the hospital experience would be better without seclusion, compared to only 21% of staff. Roberts et al. (2009) reported that seclusion was experienced by most service users as not therapeutic and a form of punishment, whereas staff mostly viewed it as an appropriate and potentially therapeutic intervention. Hoekstra et al. (2004) reported that seclusion only affects therapeutic relationships negatively when service users feel that they have been treated unfairly or when seclusion is a continual threat.

Positive effects of Seclusion

A suggested positive aspect of seclusion is escape from over stimulation; Stolker et al. (2006) reported a significant association between a more favourable view of seclusion and having resided in a multiple bed room with fellow service users prior to being secluded rather than a single bed room, suggesting that a lack of privacy on the ward makes seclusion more “attractive”. However, Veltkamp et al. (2008) did not replicate this finding; they found no significant association between views of seclusion and type of bedroom. Stolker et al (2006) identified a limitation in their own findings; single bedrooms tended to be allocated to service users who displayed more acute symptoms and possibly a lack of understanding of the need for seclusion. In Veltkamp et al.’s (2008) study, 45% of participants reported positive aspects of seclusion, including rest, security, and being able to sleep. With hindsight, 25% of participants in Mayers et al.’s (2010) study reported that seclusion was helpful or necessary. Two out of the twelve participants in the study by Meehan et al. (2000) reported therapeutic values; these included a calming effect, a feeling of protection and a feeling of safety. A limitation of this study was that the interviewer was a previous member of nursing staff, raising the possibility of bias. Participants in Hoekstra et al.'s (2004) study, whose seclusion took place "a considerable time ago", reported positive experiences of peace and safety when in seclusion, related to trust in the nursing staff. El-Badri and Mellsop (2008) found that service users reported some positive aspects of seclusion including ensuring the safety of self and others on the ward, a calming experience, and an opportunity to get out of a high stimulus environment, and some described it as "the best option at the time". The authors however suggested that the modest response of some of their participants may have been due to them feeling disempowered and therefore reluctant to express criticism or negative opinions of their care. Ray and Myers (1996) reported that a small percentage of their participants felt that seclusion was positive, and commented that seclusion was fair due to their behaviour being dangerous. However, 73% felt that they were not dangerous to themselves or others at the time of seclusion. One out of the six participants in Holmes et al.'s (2004) study viewed seclusion as positive, but the authors reported that they did not consider seclusion when it was requested by the service user. Meehan et al. (2004) found that more than half of their participants reported some positive effects of seclusion, including help to calm down and behave better, 50% agreed that seclusion was an escape from the busy ward, and 82% would like to have the choice of using the seclusion room when time alone is required. Keski-Valkama et al. (2010) found that participants reported more beneficial than harmful effects of seclusion, such as privacy, learning to control behaviour and a positive effect on their condition, however they reported that the number of participants who did not respond to the question concerning beneficial and harmful effects of seclusion was "substantial", therefore the authors acknowledged that this finding must be interpreted with caution. Martinez et al. (1999) found that 56.2% of participants felt service users would be worse off without seclusion, and concluded that if seclusion is used for specific and identifiable purposes, it can keep people safe.

Coping with Seclusion

Participants in some studies commented on coping with seclusion. Strategies adopted by service users to cope during seclusion included either regressing, acting out or compliance motivated by a need for contact with staff (Holmes et al., 2004), coping with boredom by singing, talking, yelling, or finding things to do with things in the room (Martinez et al., 1999), and talking to themselves and complying with staff requests to behave calmly (Meehan et al., 2000). Hoekstra et al. (2004) reported that coping depended on understanding the reason for seclusion, the possibility to discuss the experience and a quick recovery of control. They suggest that time is a restorative factor following seclusion, but adaptation or learning to live with the experience is more difficult if the service user feels they have been treated unfairly. Participants in this study also commented on the loneliness of having to cope with the seclusion experience afterwards.

DISCUSSION

Although some positive aspects of seclusion have been reported by service users, the results of the studies included in this review suggest that seclusion has a negative psychological impact on service users which may continue beyond the experience itself. Also, it is not only the time spent in seclusion which is potentially harmful for service users but also the way in which it is carried out. If the cautious or ambiguous nature of current guidance is due in part to the balance of service user views in previous studies, then the 13 studies reviewed here would seem to swing the balance clearly in one direction. The overall findings appear to suggest that seclusion can be a distressing experience, and therefore a good reason is needed for its use.

Psychiatric hospitals are expected to be safe, containing and therapeutic environments (Department of Health, 2002), yet interventions such as seclusion may cause further distress for service users. Seclusion is used to manage and reduce violent behaviour (NICE, 2005), but it can cause service users to feel angry and express this anger through violent behaviour. It seems reasonable to speculate that this is turn may seem to further justify the use of coercive measures of containment in the eyes of the staff, leading to a potential cycle of violence and forced containment. Involuntary hospitalisation can be extremely distressing for the individual (Morrison, Bowe, Larkin & Nothard, 1999), and being placed in seclusion involuntarily may re-enact this experience. Service users often experience stigma around being diagnosed with mental health problems, and further stigma attached to being hospitalised and excluded from society. Seclusion may bring with it renewed stigma around having to be excluded from the rest of the service users on the ward (Holmes et al., 2004). As we have seen in this review, negative experiences during hospital stays may influence service users to avoid services due to fear, causing problems to escalate and the increased likelihood of involuntary admission.

Limitations and implications for further research

The assessment of the quality of studies in this review relied on the measures taken to ensure methodological rigour being reported in the published articles. Also, some issues with quality were not included in the criteria but may have affected the quality of the study; where this is the case these issues have been mentioned in the results section.

In a review of the use of seclusion, it was acknowledged that the frequency of use and the duration of seclusion differ between institutions (Brown & Tooke, 1992). Methods and conditions of seclusion may therefore vary between hospitals and countries - in aspects such as the conditions of seclusion rooms, the frequency and duration of seclusion, and the reasons for using seclusion - therefore the results of some studies may not be comparable to each other. None of the thirteen studies were carried out in the UK; if there is evidence that seclusion is effective enough to continue to merit consideration, further research is needed to capture its psychological impact under the conditions of its use in the UK.

Another factor which may influence the perception of the seclusion experience is the service user's general experience of the psychiatric ward. Being secluded may exacerbate an already distressing experience in what is perceived as a punitive environment, or it may be perceived as a single difficult experience in an otherwise acceptable hospital stay.

The amount of time elapsed between being secluded and participating in research varied between studies; problems with recall may affect the way seclusion is viewed and therefore the psychological impact of being secluded. A small number of studies mention the longer term effects of being secluded, but more studies are needed in order to explore this. The amount of time spent in seclusion also differs between studies and between individual patients included in each study, and was reported in some papers but not others. The duration of seclusion may affect service users' perceptions of the impact of seclusion. There were two significant outliers in the reviewed papers with regard to the amount of time spent in seclusion. Firstly, in the study by Stolker et al. (2006), the duration of seclusion was reported to have ranged from 1 to 1,381 hours with a median of 37 hours. The authors reported that some service users were allowed to leave the seclusion room to spend time on the ward before returning to seclusion, and the reported durations of seclusion included breaks from seclusion for up to six hours. Secondly, in the study by Keski-Valkama et al. (2010), the duration of seclusion for the total sample was reported to range from 5.6 hours to 463.1 days, with a median of 38.5 hours. In a breakdown of seclusion duration, the median duration for the forensic group was 174.5 hours (range 9.75-11113.25 hours) and the median duration for the general psychiatric group was 17.7 (range 5.6-360.5 hours). The definition of seclusion and the physical properties of seclusion rooms may also have differed between studies, some articles provided definitions but not others, for example, some seclusion rooms were not locked, some contained furniture, some had a window, and some service users were allowed to have breaks from seclusion on the ward. All of these factors could influence the service users' perception of their seclusion experience.

In many studies, only the views of the service users who are 'well' enough to take part in research have been considered by their inclusion, therefore results may not be generalised to all service users. Those service users who are at their most 'unwell' may find themselves secluded more often and may have differing views on the effects of seclusion. Attempts to capture the views of these service users who are excluded from research participation are needed. Also, the experiences of service users who refused to take part in the research studies have not been captured; it is possible that they found their seclusion experience too painful to discuss, or they may have felt indifferent to the experience. Reasons for refusal are not provided in the articles reviewed here.

Implications for practice

Seclusion continues to be an accepted strategy for managing violent or disturbed behaviour in the UK (NICE, 2005). The recommendations for the use of seclusion in the NICE guidelines (2005) state that "seclusion should be for the shortest time possible and should be reviewed every two hours... [and] the service users should be made aware that reviews will take place every two hours". The findings of the current review support these recommendations; it is hoped that a shorter period of seclusion would minimise its negative impact, and reviews and observations would at least ensure contact with staff every two hours. The guidelines also state that "a service user in seclusion should retain their clothing, as long as it does not compromise their safety and the safety of others", "Service users in seclusion should be allowed to keep personal items, including those of religious or cultural significance (such as some items of jewellery), as long as they do not compromise their safety or the safety of others" and "there should be a designated seclusion room fit for purpose. This room should allow clear observation, be well insulated and ventilated, and have access to toilet/washing facilities". The current review also supports these recommendations; it is hoped that allowing service users to retain their own clothing and belongings would minimise the dehumanising effect of seclusion and help to maintain their dignity.

The findings of the current review suggest that there are additional recommendations which could be made in order to minimise the negative psychological impact of seclusion on service users. More effective communication is needed between staff and service users before, during and after the seclusion process. This communication would need to involve clear explanation before, during and after seclusion to ensure that the service user understands why they are being secluded and clear goals which need to be achieved in order to exit seclusion, in an attempt to reduce the likelihood of the service users feeling that they are being punished or controlled. This increased explanation may also reduce anger and frustration in response to a lack of justification. Increased contact with staff is also needed during seclusion which offers not only observation but also an opportunity to talk. This increased contact may also reduce the loneliness and boredom associated with seclusion and may have a positive impact on therapeutic relationships. Follow-up support for secluded service users may also be needed in order to monitor and alleviate any lasting psychological effects of seclusion.

The NICE guidelines (2005) recommend that more research is needed in order to examine service user views on seclusion. The current review supports this and highlights that no recent research of this kind has been carried out in the UK.

The NICE guidelines (2005) state that seclusion should be used as a last resort. The current review supports this recommendation and highlights the need for alternatives to be explored and considered, whilst acknowledging that safety measures are needed in extreme circumstances. Service users in the reviewed studies offered a variety of perspectives on seclusion. The individual needs of service users should be considered, and where possible discussions with service users about how they would prefer to be managed could prove beneficial to both service users and staff.

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THE EXPERIENTIAL IMPACT ON INPATIENT NURSING STAFF OF CARING FOR INDIVIDUALS WITH EARLY PSYCHOSIS

ABSTRACT

Early Intervention services aim to prevent psychiatric hospital admission. Little is known about the experience of hospitalisation in the context of Early Intervention for psychosis. No studies have investigated the perspectives of inpatient staff towards hospitalisation in early psychosis. Nine inpatient nursing staff took part in semi-structured interviews which were transcribed and analysed using Interpretative Phenomenological Analysis. Five main themes were identified: 1) Working with uncertainty, 2) Feeling restricted, 3) The ward as a threatening environment, 4) "You're like my bloody mother" - Working with younger patients, and 5) "Shut the doors and go home" - Coping and self-preservation. Working in the acute inpatient environment can be distressing for staff; they are exposed to high levels of distress and emotional disturbance in an environment which is chaotic and unpredictable, whilst feeling restricted in the amount of support they are able to provide to patients. However, participants in the study associated working with younger patients experiencing their first admission with closer emotional attachments and increased hope for recovery. Further research is recommended, including the investigation of the implementation and outcomes of the productive ward programme, the use of clinical supervision with inpatient nursing staff, and the meaning of needing support.

INTRODUCTION

Psychotic illnesses typically develop in late adolescence and early adulthood (Harrop & Trower, 2001). Early Intervention services (EIS) target service users in the early stages following the onset of psychosis. Research suggests that the first five years following a first episode of psychosis should be considered to be a ‘critical period’ predictive of longer term outcomes (Birchwood, McGorry, & Jackson, 1997). EIS aim to prevent admission to psychiatric hospital and promote recovery by reducing the duration of untreated psychosis (which is associated with involuntary hospital admission), offering biological and psychosocial interventions, assisting service users in coming to terms with their experiences, and by minimising the impact of psychosis on social and work functioning (Spencer, Birchwood, & McGovern, 2001). A further aim is to reduce adverse reactions to the experience of psychosis and to receiving treatment (Newton & Birchwood, 2005) such as involuntary hospitalisation.

Psychiatric hospitalisation can be distressing for service users; Morrison, Bowe, Larkin, and Nothard (1999) found that 44% of people who had been admitted to an inpatient psychiatric ward showed signs of post-traumatic stress disorder in relation to the admission. Myers, Leahy, Shoeb, and Ryder (1990) investigated the views of 258 patients in four English psychiatric hospitals, and found that 65% of patients made negative comments regarding their experiences of inpatient care.

Little research has been carried out into the experience of hospitalisation in the context of Early Intervention for psychosis. O’Toole et al. (2004) gathered service users’ views of services for first episode psychosis. Patients were complimentary about community services, but expressed negative views about their experiences of inpatient psychiatric care.

Inpatient staff perspectives

In a literature search of the electronic databases PSYCINFO and MEDLINE for articles related to staff, psychosis and hospitalisation, no studies were identified which have investigated the perspectives of inpatient nursing staff on hospitalisation in early psychosis. The attitudes of these staff towards their work and towards patients may influence the quality of care which they provide. Early Intervention service users carry a risk of disengagement from services and adverse experiences in hospital may contribute to this risk of disengagement (McGovern, Hemmings, & Cope, 1994). It is, therefore, important to study the experiences of hospitalisation from all perspectives including the experience of the nursing staff who are required to form therapeutic relationships with these service users.

Interacting closely with hospitalised patients may feel difficult due to the acute nature of their distress. Nordt, Rossler, and Lauber (2006) compared Mental Health professionals' and general public attitudes towards people with a diagnosis of schizophrenia, and concluded that despite their superior knowledge, professionals displayed the same number of stereotypes and the same level of willingness to interact closely with "mentally ill" people as the general public. However, Vibha, Saddichha, and Kumar (2008) found that psychiatric ward attendants had more positive attitudes than general attendants towards "psychiatric illness". More positive attitudes were related to older age, higher education and longer duration of contact with the "psychiatrically ill". Prolonged experience of working with acutely disturbed patients may lead to staff feeling more able to tolerate their distress, or conversely to a detachment from the difficult emotions evoked by close contact with them (Maslach & Jackson, 1981).

Inpatient nursing staff are expected to create an environment where acutely distressed patients' conditions can improve, which involves a wide range of responsibilities: Using thematic analysis of qualitative interviews, Hurley (2009) proposed seven elements of the mental health nurse (MHN) identity; the MHN as generic specialist, the MHN as adopting a service-user focus, the MHN as positioning and utilizing the personal self, the MHN as spending time with the service user, the MHN as delivering talk-based therapies in versatile ways, the MHN as having an everyday attitude, and the MHN as having transferable skills. These findings suggest that the attitudes of inpatient nursing staff towards working with patients with early psychosis will have developed from the perspectives of a number of different roles.

The impact of the work on staff

Working on an inpatient ward with people in acute crisis requires staff to deal with extreme situations in an intense environment, and the emotions evoked by working with people who are admitted to hospital at their most distressed or disturbed have to be tolerated along with the distress of the patient (Winship, 1995). Staff may be seen as the stable constant in a chaotic and unpredictable environment within which the patient group is constantly changing. The emotional impact of working in these conditions in positions of responsibility may affect their efficiency, and in turn, the quality of patient care. Psychiatric nurses hold 24-hour accountability for the integrity of the inpatient treatment environment (Delaney, Perraud, Johnson, & Sharfstein, 2009), and the risk of burnout may be high (Sorgaard, Ryan, Hill & Dawson, 2007). Maslach (2003) describes the three key dimensions of burnout as i) Emotional exhaustion, ii) cynicism and detachment, and iii) a sense of ineffectiveness and lack of accomplishment. Workplace variables associated with these dimensions were identified as work load, social conflict and a lack of resources. A systematic review of staff morale in acute inpatient units resulted on the proposal that, while levels of burnout may be moderate, job satisfaction may be high; organisational issues (such as job characteristics and management) or psychological variables (such as adequate social support) were suggested to be the main factors contributing to occupational stress (Cahill, Gilbody, Barkham, Bee, & Richards, 2004). Sorgaard et al. (2007) found no differences in burnout between acute ward and community staff; acute ward staff reported a worse social environment and a lack of control, but were more satisfied with the organisational structure and had easy access to colleagues during the work. Bowers et al. (2009) proposed that morale was higher than published comparison samples. Low morale was correlated with length of time in post, the level of verbal abuse on a ward, and a higher level of social deprivation among patients, whilst better morale correlated with higher levels of organisation and order. Aronson, Sieveking, Laurenceau, and Bellet (2003) found that employee satisfaction was strongly related to the actions and attitudes of management, how employees perceive the quality of patient care, and the extent to which employees believe the hospital serves the greater community.

In summary, the impact on staff of working in an environment associated with high levels of occupational stress, low morale and a risk of burnout must be considered in terms of their effect on the patients' hospitalisation experience, especially younger patients experiencing their first admission who may be difficult to engage and who may subscribe to negative stereotypes and societal fears associated with mental health services.

Rationale for the current study

Staff morale is an important predictor of positive patient experience (Bowers et al., 2009). Little is known about the psychological impact and phenomenological experience of staff working with Early Intervention service users who have been hospitalised. Young people and patients with early psychosis who have perhaps unexpectedly been hospitalised for the first time are likely to have some distinctive needs, for example, preparation about what to expect, information about interventions, extra support for distress and disorientation, and psycho-education about psychosis, and a symptom-based approach due to diagnostic uncertainty (McGorry, 1995). It is therefore important to know more about staff experiences of working with such patients. It is hoped that staff insights into the needs of patients and their families, and the experiential impact of this work on staff, will contribute to the improvement of services for people experiencing an early psychosis and their families. The current study therefore aims to gain some understanding of the experience of caring for young people with early psychosis in an inpatient unit and the impact of the work on the staff providing inpatient care in this context as a necessary step towards the improvement of services for people with early psychosis.

METHOD

Design

Nine participants were interviewed using a semi-structured interview schedule. Interview transcripts were qualitatively analysed using the principles of Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009). This study was conducted as part of a three-way multi-perspective study, with other members of the research team carrying out similar studies on the impact of hospitalisation in early psychosis with patients and families.

Participants

Nine inpatient nursing staff of two acute psychiatric units, who had worked with early intervention service users in the last 12 months, were recruited to take part in the study. They included both qualified and unqualified nursing staff with varying levels of experience in inpatient care. Table 3 contains demographic information on the participants. Names have been changed in order to maintain confidentiality. A small, purposive, homogenous sample was used in accordance with IPA principles (Smith et al., 2009). This allows for a focused, detailed account of the experience of nursing staff in this context. Inpatient staff other than those in the nursing profession (e.g. psychiatrists, occupational therapists, or psychologists) were not included in the sample in order to maintain homogeneity.

Setting

Participants were recruited from two inpatient units operating in the same NHS partnership trust. One unit was located in an urban area and included three mixed acute wards, one female-only ward, and one psychiatric intensive care ward, with a total of 85 beds. The other unit was set in a rural location and included two mixed acute wards and one psychiatric intensive care ward, with a total of 41 beds, and two rehabilitation wards with a total of 26 beds. It should be noted that the current study took place during a time of particular financial challenge for the NHS.

Table 3: Participant demographic information

Name	Age	Gender	Ethnic Origin	Profession	Years in profession	Years in inpatient services
Sally	39	F	White British	Nursing Assistant	6	6
Janet	ND	F	White British	RMN & Acting ward manager	12	34
Heather	33	F	White British	RMN & Ward manager	9	9
Jill	38	F	White British	RMN & Deputy ward manager	12	12
Paul	41	M	White British	RMN & Deputy ward manager	17	17
Sue	51	F	White British	Nursing Assistant	10	10
Karen	41	F	White British	RMN Staff Nurse	10	14
Rachel	23	F	White British	Nursing assistant	1.5	1.5
Linda	46	F	White British	RMN Staff Nurse	1	6

Note: RMN=registered mental health nurse, ND = not disclosed.

Procedure

Ethical review was undertaken and approval to carry out the research was granted (Appendix II). Potential participants were invited to participate in the research on a number of visits to each unit. A participant information sheet (Appendix III) and consent form (Appendix IV) was provided. Interviews lasted between 20 and 60 minutes and took place in a room off the ward. A semi-structured interview schedule (Appendix V) was developed by the research team which contained open-ended questions intended to prompt participants to give a detailed account of their story. The questions focused on the job itself, young patients' experiences on the unit, and the staff's experience of working with young people on the unit. The interview schedule was used flexibly to guide conversation whilst following the participant's own concerns. Interviews were audio recorded and transcribed, and were anonymised at the point of transcription.

Analysis

The objective of the study was to find out about the experience of nursing staff working with people with early psychosis. The choice of the method of analysis was guided by this objective; to obtain detailed information on an area which has not previously been explored. Interpretative Phenomenological Analysis (IPA) is a method of analysing qualitative data which is concerned with the subjective experience of the participant and the meaning of this experience to the participant (Smith et al., 2009). It is based on the principles of phenomenological psychology, which focuses on the way people make sense of their own experiences and perspectives on the world in order to achieve meaning in context. IPA is also influenced by idiography, which focuses on the particular rather than the general; it is therefore possible to make claims at an individual level rather than at a group or population level. A third influence on IPA is hermeneutics, which involves interpretation by the analyst of the meaning of phenomena to the individual (Smith et al., 2009).

Although there are standard principles of IPA, the procedures of analysis can be implemented in flexible ways (Smith et al., 2009). The IPA analysis in this study followed a number of steps (Larkin & Thompson, in press), and moved from the particular (each participant) to the general (across participants), and from the phenomenological to the interpretative.

The first step involved reading and re-reading the data, and 'free' coding by noting any initial ideas to identify any first impressions and preconceptions which needed to put aside in order to focus on the data itself.

The next stage involved the line-by-line phenomenological or descriptive coding of the transcripts, noting the experiential claims and concerns of the participant.

Remaining at the individual transcript level, the next step was to identify emergent themes through noting patterns that were repeated throughout the experiential material of each transcript. This involved a shift towards more interpretative coding of the data.

Once these steps had been completed for each interview transcript, themes across transcripts were searched for and identified, and a structure of super-ordinate themes and sub-ordinate themes was developed.

At this point, the structure of themes and subthemes was checked by two other members of the research team for the purposes of triangulation and validity checking. The outcome of this was an agreement on five super-ordinate themes emerging from the data.

In order to demonstrate the procedure of the analysis, examples of descriptive coding and structuring themes can be found in Appendix VI and VII.

RESULTS

A total of five super-ordinate themes were identified in the analysis. These are summarised in Table 4.

Table 4: Summary of super-ordinate and sub-ordinate themes

Super-ordinate Themes	Sub-ordinate themes
Theme 1: Working with uncertainty	Individuality of patients Unpredictability of the working day Changing patient group
Theme 2: Feeling restricted	Limitations of staff Limitations on patient contact Insight The limited role of acute care Limits on activities/ boredom
Theme 3: A threatening environment	Fear Risk of violence and aggression A non-therapeutic environment
Theme 4: "You're like my bloody mother" - Working with younger patients	Youth Feeling like a parent First admissions Hope
Theme 5: "Shut the doors and go home" - Coping and self-preservation	Switching off Detachment Needing support Supporting each other

Theme 1: Working with uncertainty

All of the participants commented on the uncertainty and unpredictability of the work. This uncertainty had three related aspects: individuality of patients, unpredictability of the working day, and changing patient group.

Individuality of patients

Most participants were concerned with the individuality of the patients, in which every patient is different and therefore must be treated and thought about individually. Participants recognised that everyone's experiences are different, even within diagnostic categories, suggesting that a diagnosis does not enable them to predict what a person will be like. Patients are unpredictable in their reactions to admission and in the way that they interact with staff and other patients:

"Some people can be withdrawn, some people can, as soon as they come on the ward some people can be quite violent, we have to deal with each situation that comes up really, you know, some people react differently, erm, [PAUSE] some, just each situation, each person is diff-, totally different." (Sue, line 130)

Both in this example and across the data it is implied by the participants that their work is reactive, and rather than being able to plan for how a patient may behave, each situation must be dealt with as it arises, and therefore flexibility is required. Sue also mentions here the risk of violence from patients, which introduces an element of fear into the unpredictable nature of the work.

The individuality of patients also extends to their prognosis; nursing staff are unable to predict how much a patient's condition will improve during their admission:

"You sort of can never sort of can say to anybody "oh you're only going to be here for a couple of weeks" because you never, you never can say that because you don't know." (Linda, line 309)

Unpredictability of the working day

The unpredictability of the working day relates to the inability to plan anything, as every hour is different, and the feeling that the work is inevitably reactive rather than pro-active. An example of this is provided by Sally:

"I don't think you really have time to think about it, you just, I think because every day, every hour is totally different, we could have a ward that's settled and then it just escalates, one person will, say, be violent, then another person, it just, I don't think you get time to cope you just, you just get on, to be honest with you, I mean you could go and find someone hanging, in a room, and then five minutes later, you're making beds, you know, it's just, the whole, the whole shift you can't ever plan anything [...] some shifts you don't even get time to talk to anyone, some shifts you can sit in the garden all day and you know, have a good chat and a laugh with them, so it's just, whatever challenges come, it's just dealt with there and then sort of thing." (Sally, line 522)

Sally illustrates here the perceived lack of time and capacity to think about what is happening during a shift. There is a sense of urgency in the way the escalation of violence on the ward is described by participants, in that it is something that spreads to other patients and is difficult to control. The stark contrast between finding someone hanging and making beds five minutes later highlights how little opportunity there is to process disturbing events; they have to be dealt with on the spot. The contrast between this and a shift where you might be sitting in the garden talking all day suggests that there will be shifts which are less busy and more enjoyable, but that it is impossible to predict when they will occur.

The work for some participants is not what they expected when beginning the job; the uncertainty and unpredictability of the work may have come as a disappointment:

"I suppose I, I did expect it to be a lot more about you know, you would be spending time helping people, talking to them, offering interventions, offering sort of you know therapies, but a lot of the time it's not about that it's about crisis management, you lurch from one crisis to the next and, and you manage that as it happens." (Jill, line 78)

The act of lurching from one crisis to the next suggests that often one urgent situation is not completely resolved before another one arises, and that staff find themselves in a constant state of anxious alert.

Changing patient group

The patient group on an acute ward is constantly changing; patients leave and new patients arrive frequently, and so the caseload of patients is not consistent. This adds to the uncertainty and unpredictability of the working day:

"I mean I could come in tomorrow and there could be ten new, different patients I've never met before, and they could be gone the next time I come on, so it's different, it's different all the time, it's a different challenge every day." (Sally, line 540)

The lack of continuity of the caseload of patients which staff find themselves working with means that they are often not prepared for who they will meet on arrival for a shift.

In summary, the theme of uncertainty was evident throughout all of the interview transcripts. An important element of this theme is not having time to think about coping with the uncertainty which staff are constantly faced with. The effect of the uncertainty and unpredictability of the work is understandably a felt lack of control, and the reactive nature of the work may mean that staff find themselves in a constant state of arousal which is not felt to be contained. Bion (1959) proposes that containment involves feeling able to process emotions whilst retaining the capacity to think. The acute inpatient environment may not feel containing for staff due to the felt lack of opportunity to think about and process their experiences, and therefore the staff are expected to contain the distress of the patients whilst feeling uncontained themselves.

Theme 2: Feeling restricted

All of the participants contributed to the theme of feeling restricted. This theme includes five dimensions of restriction: limitations of staff, limitations on patient contact, insight, the limited role of acute care, and limits on activities/ boredom.

Limitations of staff

Most participants described feeling limited in the extent to which they can help patients, due to lack of time, staffing pressures and safety concerns, and there is a suggestion that staff have to accept their limitations in order to cope:

"You do your best. It's not perfect, never is, erm, but you try your best for the patients and, you know, erm, sometimes it works, sometimes it doesn't, it just depends on how, how busy you are, I mean there's only five people on every shift, and you've only got a certain amount of time." (Paul, line 519)

Paul recognises here that doing his best is sometimes still not enough to help people. There is not enough time for staff to do their best with every patient, and therefore they are not capable of helping everyone. As well as limitations of time there are limitations due to safety regulations:

“We are very limited with safety, really, erm, if someone's in and they're on observations they don't have leave from the ward, you know we are very restrained by that.” (Heather, line 275)

Heather highlights here that the staff feel ‘restrained’ in what they can do, perhaps identifying with patients who may find themselves physically restrained by staff in order to maintain safety.

Limitations on patient contact

The lack of patient contact is felt by many participants to be due to an increase in paperwork, and may obstruct the development of therapeutic relationships:

“The other challenging side of it now is [...] documentation rules everything, there's documents for everything now, and it's very time consuming, and that's challenging [...] to have to, you know, meet all these requirements, a lot of the work, in some respects you spend less time with the patients now and more time filling in paperwork to meet targets and that's, that's difficult.” (Paul, line 150)

Some participants voiced frustration because they feel as if documentation comes before patient care. For other participants this was accompanied by sadness, because *“it takes you away from the patients which, I find that quite sad, really”* (Janet, line 631). Paul also commented on the effect of this on the patients, stating that *“the result of that sometimes is frustration on the patients' part, they get frustrated and, you know, angry”* (line 536). The anger and frustration felt by patients is accompanied by a sense that the only solution to this problem would be to have more staff on the ward. Hardcastle, Kennard, Grandison, and Fagin (2007) suggest that staff in inpatient mental health care may utilize the requirement to focus on paperwork to protect themselves from “over-exposure” to interactions with patients who are acutely emotionally disturbed and distressed.

Insight

Insight relates to some patients' limited understanding of their mental health problems, which is seen by the participants as a significant challenge when working with someone, and may restrict their progress:

"You do get lots of youngsters that don't accept obviously that there, there is some psychotic element to their illness, and, as a consequence of that they're non-compliant, a lot of the youngsters, they get to a stage where they feel well, and they stop taking their medication, and subsequently they're re-admitted, erm and I think, you know, it's, it's quite sad really, the amount of youngsters we do get in." (Janet, line 57)

Janet speaks of her sadness here that many younger patients lack insight and therefore stop taking their medication, resulting in re-admission. An assumption is made here, and elsewhere in the data, that the medical model always applies, and that readmission is a result of non-compliance with medication. This may be because the psychiatric hospital is an environment where the medical model dominates (Parker, Georgaca, Harper, Mclaughlin & Stowell-Smith, 1995), consultant psychiatrists have the final say in decisions, and medication is often considered the best option in the short term treatment of acute psychotic episodes (Department of Health, 2002). However, some participants acknowledged that medication alone is not always helpful, for example, Sally stated *"it needs a whole package but I think here it's just medication"* (line 320).

Karen also highlights the challenges associated with patient insight:

"If it's a psychotic episode, or, or even, you know, something like bipolar, they might be enjoying the experience that the, the way they're feeling, and lack insight [...] so that is the greatest challenge with somebody experiencing a mental health problem for the first time,

it's about education [...] because obviously if they can get some insight then it's going to reduce their chances of coming back again, which is what we want." (Karen, line 222)

Karen speaks here of patients who are "enjoying" their first experiences of mental health "problems"; this idea may be difficult to comprehend because the concept of enjoying a problem or illness seems incongruous, and there is an assumption that this must relate to a lack of insight. Karen suggests that education is needed because insight is desirable, and that awareness of the "problem" and a perceived need for treatment is a requirement for recovery. A meta-analysis of studies on insight in psychosis found that acute inpatient status was significantly correlated with the relationship between insight and positive symptoms (Muntz, Dobson & Romney, 2003), suggesting that increased positive symptoms and decreased insight are to be expected during acute episodes.

The limited role of acute care

The limited role of acute care relates to the fact that the patients are often acute inpatients for a short period of time; some participants reported that their aim is to stabilise them and discharge them, and most participants feel that they are there to manage emergencies rather than engage in therapeutic work:

"I think what we get here is we get people probably sometimes at their worst, get them to a point where they're stable enough but we never get to do the long term work [...] I think that's, that's part of the job and you get used to it." (Heather, line 527)

Some participants expressed resentment towards community services which are felt to have the opportunity to do long term therapeutic work with patients who are not at their worst, and which are thought to have more resources allocated to them. Heather and some of the other participants remarked that they have had to get used to having this limited role because there is nothing which can be done to change it. There is a suggestion that the role in acute inpatients has changed; at one time it did involve working therapeutically with people:

"So it is mainly about crisis management now it's not necessarily about erm anything therapeutic [LAUGHS] it's about getting them to a stage where they're well enough to go back into the community and then have those services, erm, so perhaps I'm now in the wrong job!" (Jill, line 593)

Jill and many of the other participants expressed their preference for working more therapeutically and the feeling that the role has changed around them over time.

Limits on activities/ boredom

Most participants commented on boredom for patients on the ward. This is in stark contrast with the staff feeling that they are never bored and every day is different. Many participants commented on the impact of boredom on mental health:

"boredom it's just one thing that they all say, and that does have a big impact on their mental health[...] when you're bored, and agitated, it's not a good mix really." (Sally, line 679)

Sally suggests here that the patients' boredom may contribute to the level of agitation on the ward, and a number of participants believe this may lead to aggression. Other participants commented that patients who were bored had too much time to think and dwell on their problems, and may become more depressed. Some pointed out that often patients are not well enough to take part in activities, and when they are well enough it is time to consider moving them on. Some participants spoke of the inevitability of boredom on the ward due to the restrictions on activities:

"I mean like at weekends we do walking groups, but you can guarantee the people that want to go on the walking, walks, have got no leave. It's quite frustrating, you think [SIGH] but obviously you understand." (Linda, line 414)

Participants expressed their frustration at organising things for people to do who are then unable to do it due to safety regulations and restrictions, but acknowledged that there is nothing that can be done to change this.

Feeling restricted in the level of support which staff feel able to provide to patients conflicts with the identity of nursing as a caring and helping profession, and may incite feelings of hopelessness and frustration. Maslach (2003) identified a sense of ineffectiveness and a felt lack of accomplishment as a key dimension of burnout, and proposed that this is at least in part related to workplace variables, such as a lack of resources, as well as personal variables.

Feeing restricted may also contribute to feelings of anxiety and guilt about failing to help patients, and anxiety about exposure to their acute distress and disturbance. Staff may use the lack of patient contact and the limitations of the system of acute care as an unconscious protective defence against their anxieties about failing to help patients and fears of being overwhelmed by their disturbance, as suggested by theories of social defence systems (Menzies, 1960). This way of distancing the self from difficult emotions could be seen as a form of detachment which is felt to be necessary in order to cope with the work.

Theme 3: A threatening environment

All of the participants described the ward as a threatening environment. This threatening environment includes three elements: fear, risk of violence and aggression, and a non-therapeutic environment.

Fear

Most of the participants observed that the ward is a frightening place for patients due to the unusual behaviour of other patients, noise and unfamiliarity, and this leads to patients isolating themselves:

"It's scary. And also we have to appreciate that sometimes if people don't come out of their bedrooms it's not because they don't want to it's because they're scared to, you know I don't think I would like to come to an environment like this and go and sit in a lounge full of, you know, people shouting and screaming and stuff I'd probably keep myself in my room, and I think sometimes when we're doing observations on patients saying "oh they're not coming out of their room", we have to sometimes step back and think "would you?", you know, it's about having that sort of realism." (Heather, line 224)

Participants observed that the ward is a place which most people would try and escape from by staying in their bedroom, and putting herself in the patients' position helps Heather to think about why. The description given by many participants of a place full of people shouting and screaming paints a powerful image of a chaotic environment which is particularly frightening for patients who are admitted for the first time. The nursing staff find themselves working in this environment for long periods of time, and most participants feel they have had to get used to it:

"I think it's something, if you work here on a daily basis you become immune to it, and I think sometimes you do have to reflect on what the ward environment is like, [...] it's sometimes bad enough to be here for twelve hours a day, in theory in a position of where you're in some kind of control or authority, but to be a patient on this ward, I wouldn't want to do it." (Karen, line 89)

Karen acknowledges that it is a "bad enough" environment to work in, hence being a patient on the ward must feel even worse. Karen alludes to "in theory" being in a position of control or authority, suggesting that she does not feel that this is the case. Many of the participants said that they would not want to be a patient on the ward, and therefore they may find themselves in a difficult position when trying to support patients to benefit from being admitted. The staff may at times project their own fear in response to the ward environment onto the patients. This subtheme links strongly to the next subtheme, as the main source of fear for staff was identified as the risk of violence.

Risk of violence and aggression

Most participants commented on the risk of violence and aggression between patients and towards staff, which creates anxiety and apprehension:

"Luckily I've not had anything too horrific, but when I know that, that it's going to happen or, you know, it, it's happened to somebody else on the ward it makes me feel a bit, you know, I'm not completely myself on the ward again [...] you sort of withdraw a bit and you, you're a bit more wary than what you usually are [...] you can't do your job as well I think, because you're sort of thinking about that person, at the back of your mind you're thinking, you've got to think, think about where they are or what they're doing." (Rachel, line 97)

Rachel implies here that she feels lucky not to have been involved in a violent incident, and when they do occur then her ability to work is affected due to fear of re-occurrence. Many of the participants spoke of the inevitability of violence and aggression on the ward, due to the environment in which the patients find themselves:

"If they are acutely unwell and there's noise and there's people coming into their faces and they're psychotic, it's going to, you know, there's going to be a reaction." (Karen, line 108)

Karen implies here that the occurrence of violence and aggression between patients on the ward is not surprising due to the nature of the patients' presentations and the fact that a number of "acutely unwell" patients are expected to tolerate each other's behaviour.

Aggression towards staff is mentioned by many participants as something which you learn to tolerate over time; Janet commented that *"it just goes over my head, I mean if I get abuse, if I get, get verbal abuse that's fine, I mean, I've dealt with it for thirty-odd years it's not going to, it's just going to roll of my back anyway [...] so that, that doesn't bother me at all"* (line 550), suggesting that being a target for aggression is accepted as part of the job.

A non-therapeutic environment

The ward is seen as a non-therapeutic environment, which conflicts with the idea that patients come to hospital to be helped, and to feel safe:

"I think the environment, like the decor and things, that's, I think that has a huge impact on people's health, as that can be like detrimental if people are sitting in dark, horrible rooms." (Linda, line 409)

Linda provides an image of "dark, horrible rooms" in which people are expected to feel better, but may make them feel worse. Sally adds to this in relation to the younger people who find themselves admitted to the ward:

"I don't think it's the right place for a young person to be honest with you, I really don't. Erm, I wouldn't be happy, if it was one of my kids I wouldn't really be happy for them to be in here, so, erm, I'm not saying it doesn't help some, because it does help some. But I think sometimes it can make them, a lot worse." (Sally, line 324)

Sally empathises here with the carers of the younger patients. Many participants suggested that hospital admission can help some people, but that being in the ward environment can sometimes make people worse, which is the opposite effect to that which is intended.

In summary, the ward environment is felt to add to the limitations on patients' conditions improving, and this may relate to the theme of feeling restricted. Staff seem to cope with the environment by getting on with it, becoming immune to it and seeing fear and aggression as part of the job; acceptance and detachment from their feelings appears to be their response when a situation feels hopeless. Most staff describe the ward as an environment which is especially threatening when it is unfamiliar, and that over time you become unaffected by it. This suggests that the detrimental effects of the ward environment are most significant for patients who are admitted for the first time.

Theme 4: “You’re like my bloody mother” - working with younger patients

All of the participants talked about both the challenges and rewards of working with younger patients. This theme manifests itself in four different ways: youth, feeling like a parent, first admissions, and hope.

Youth

The attitudes of some participants towards young people reflect some of the stereotypical views of society; they form cliques and influence each other, they can be contemptuous towards older people, and display childish behaviours. Paul gave an example of some young patients’ attitudes towards staff:

“It can be quite, erm, challenging, you know, you, they see you as an older person, you know, as all young people do, you know, "old git", you know, "what does he know about anything?", so yeah, you can get that sort of experience, [...] and it can be difficult to engage with them because, like I say they see you as some, you know, older person, non-entity, you know, "why would I want to sit and talk to you about what goes on in my life?"” (Paul, line 233)

Paul paints a powerful image here of himself in the eyes of a younger patient, and highlights the hostility that staff can find themselves faced with when working with young people. Janet also describes this experience as *"difficult [...] especially when you've got a group of them because they're quite boisterous as well being, given the age they are, quite boisterous."* (line 164). It was acknowledged by some participants however that this depends on maturity rather than age.

Conversely some participants talked about how it can be difficult to maintain boundaries with the younger patients, because *"I think you do definitely tend to become more emotionally attached when it's someone younger"* (Jill, line 856). This strongly relates to the subtheme of feeling like a parent.

Feeling like a parent

All but one of the participants likened their role with younger patients to that of a parent, either feeling maternal towards them, and therefore more emotionally attached, or wanting to be a role model for them:

"I treat them like my own, to be honest with you.... one of them said to me the other day, "you're like my bloody mother you are", er and I said well, you know, I'm trying to be, but it's only trying to guide you kind of thing." (Janet, line 540)

Some of the participants commented that being a parent means that they compare the younger patients to their own children, and feel they need to look after them and guide them. They make sense of their caring behaviour towards younger patients by acknowledging that they are parents themselves, and therefore younger patients activate systems of attachment. Some also alluded to the idea that when the patients are in hospital the nursing staff become their carers in place of their own parents, and that this must be difficult for the patients' parents:

"But it's almost, I suppose as a parent you would do, they're trying to be the carer, they're trying to solve the problems even though they're still in hospital, they're still taking on that role almost, but then I suppose it's hard not to." (Jill, line 725)

Some participants acknowledged the need to be a role model for patients who have perhaps not had effective parenting in their lives:

"Sadly some of the people that come in haven't had any role models, I can think of a few patients like that who have had, you know, what you would describe as dreadful childhoods, and er, well no childhood at all to speak of so, yeah that's important as well, to try and be a role model to them." (Paul, line 216)

Paul speaks here of his sadness at hearing about some patients' experiences as children, which motivates his to attempt to redress this.

First admissions

The subtheme of first admissions also relates to the theme of unpredictability; when a patient is not previously known to services and may not have received a diagnosis, staff feel they are more at risk of making the wrong judgements, leading to feelings of fear and a lack of control. Heather compares this experience to working with some of the more chronically ill patients:

"Someone with a long history you can almost, you can read back in the notes and there's, there's a pattern but obviously with the young ones, this could be new, you know we don't know what's causing it, we don't know a lot, they probably haven't got a diagnosis, things like that, these are all still, sort of under investigation, so it's all new and it's all learning." (Heather, line 538)

Staff are highly motivated to work with patients who are experiencing a first episode of psychosis; it is felt that it is important to 'catch them early' in order to prevent further admissions, and therefore there is an attempt to spend more time with them. Most of the participants agreed with this, including Rachel:

" I think just, because they are so young, you want to try and help them as much as they can so they don't sort of have to keep in the system and have to keep coming back in [...] and I think that's sort of, that's, especially when it's their first time in and you think right, if they're in now, help them as much as you can so they're, they're not back in and they don't, you know, don't end up coming, getting into that sort of cycle of going home and then coming back in." (Rachel, line 452)

This relates strongly to the subtheme of hope.

Hope

Working with patients who are admitted for the first time introduces an element of hope into the work; most of the participants feel that there is more chance of helping someone if they are still in the early stages of their illness, which relates to the idea of a "critical period" in early psychosis (Birchwood et al., 1997). Jill provided some reflections on this:

"I think it is quite a thankless job in a lot of ways, you know you don't, you don't get to see it because you do get lots of patients who are, erm, in and out constantly, so you know, almost you know you're not going to make any big difference with their lives, you're not going to, you know it's too, too far, too late, so I suppose with people who you are looking at the first time, you know, you are kind of hopeful that you've done something, you've made a difference, you've helped, and you'll never see them again, they're, they're going to recover and go on to erm, you know, have a decent life [...] and hopefully not be in and out of hospital for the next twenty years." (Jill, line 349)

The job is described here as "thankless", suggesting that staff often feel unappreciated and unrewarded for their work, particularly when working with patients for whom it is felt to be “too late”. It is felt that there is no hope for these patients, and a sense of something being so broken that it cannot be fixed. The exception to this is the feeling that with younger patients there is a chance that a difference can be made to someone’s life and that there is hope for recovery.

In summary, working with younger people who are experiencing a first episode of psychosis involves tolerating being an object of contempt and a high level of emotional involvement and responsibility; however it also provides an invigorating element of optimism for nursing staff, who often feel they are unable to make a difference to people within the limitations of acute psychiatric care. This optimism may relate to the idea of a “critical period” in early psychosis, during which it is thought possible to influence a patient’s prognosis (Birchwood et al., 1997).

Theme 5: “Shut the doors and go home” – Coping and self-preservation

All of the participants commented on coping and support. This theme includes four related aspects: switching off, detachment, needing support, and supporting each other.

Switching off

There was agreement between most of the participants that switching off and leaving work at work is necessary in order to cope with the work and maintain your own mental health, because *“it sort of can play on your mind, but you've got, I think you've got to learn to be able to sort of switch off, otherwise it's not healthy really”* (Linda, line 362). Switching off seems to be something that some participants find easy:

"I very much have a shut the doors when I leave here and go home and work's left behind me, because I have enough ports that I can ventilate and, sort of, get support whilst I'm here, I do feel quite lucky in that respect." (Heather, line 606)

Heather suggests that leaving work at work and not thinking about it at home is an option for her, as she feels that she can speak to others on the ward about concerns she may have. She acknowledges that she is lucky to be able to do that, whilst some participants find this more difficult:

"If you've had a really busy shift, by the time you get home, I could be on a late till half nine at night, and it could have been a busy, manic shift, with loads going on, like, the other week we had a big fight and everything and then you go home, and you're like, you're on an early the next day, and you can't wind down because you're that, you know, your adrenaline is still sort of going." (Sally, line 559)

Sally illustrates here that sometimes a shift can feel so chaotic that winding down from it would require a period of time which is not always available due to shift patterns.

Detachment

Detachment from the work and from the patients is deemed by many participants to be necessary for self preservation:

"As a student when I looked at these people that were cynical and seemed burnt out or didn't seem to care [LAUGHS] and you think that, that's kind of almost er, a defence, er not a defence mechanism that's the wrong word, it's erm, self preservation almost, erm, you can't, you know, I think I learnt quite early on that you can't take on everybody's problems, you can't, you, it's not physically possible for you to do it as a, another human being you can't cope with everybody else's, and you can't, ultimately you can't solve other people's problems for the, you, you can't, and a lot of the time you can't even get anywhere

close to even helping sometimes [...] so I suppose yeah it's about, it's about that, it's about learning to detach that bit more and to not get so involved and frustrated at things that you can't change." (Jill, line 922)

Jill acknowledges here that, even when starting the job with different intentions, eventually it is necessary to be cynical and not caring in order to detach, and to cope with the frustration of not being able to help someone. This relates to the theme of feeling restricted and having to accept your limitations, however the idea of detachment conflicts with feeling more emotionally attached to the younger patients. It seems that depersonalisation occurs more often towards more "chronic" patients in order to avoid the feelings of impotence and hopelessness, but that this is not the case for younger patients, for whom there seems to be some hope.

For most participants, 'getting on with it' seemed to be the default way of coping, in the absence of an alternative:

"I just keep trying. I don't [LAUGHS] well what else can you do? It's [PAUSE] I mean it's, I just get on with it. I have no specific formula or answer." (Karen, line 241)

Interestingly, Maslach & Jackson (1981) propose that the development of cynicism and detachment in healthcare staff is due to a depletion of emotional resources. In response to this, staff "distance themselves emotionally and cognitively from the work" (Maslach, 2003). It is worth noting that emotional exhaustion and cynicism/detachment are both identified by Maslach (2003) as key dimensions of burnout.

Needing support

The views of participants around needing support differed; some felt that support was available but felt unable to ask for it, whilst some felt that they needed more support than was available:

"We had a young girl that died, took an overdose, found dead, you know, and, no nothing, really, we don't really, there's not a lot of support, we get support off the nurses, you know, they'll come and see if we're ok sort of thing but there's not really, generally any time, for any other kinds of support really. I suppose if we ask for it, there might be something, but... but it's forgotten about." (Sally, line 572)

Staff can face extreme situations, such as suicide, which are seen as part of the work rather than as something which would require support and debriefing; there is no opportunity to process and think about these experiences. The act of not stopping and reflecting may serve a purpose; to avoid painful feelings associated with distressing situations. It may be that asking for support is seen as a sign of weakness, and it is more desirable to forget about what has happened. Some participants felt that support is only needed by staff who have been in the job for a long time due to a cumulative effect of stress; Sally goes on to propose that *"some of the staff probably do need counselling, over the years, you know, things you've seen"* (line 656). Some participants expressed that they did not recognise a need for support at all; for example Janet states *"I don't need support! I am here to work [...] it's a job!"* (line 564) suggesting that being at work means she does not need to be supported when things are distressing, she is there to work, and needing support would mean she was unable to do the job.

Supporting each other

All of the participants commented on working as a team and supporting each other, and most said that sharing concerns and frustrations with each other is necessary for survival in the job:

"I mean I do have a lot of informal stuff [...] because you learn over the years that that, like I say if you want to sort of survive in this job, you've got to do it, if you don't you won't

[...] I've seen a lot of people just bottle it up and then they, they just leave, they just can't deal with it, so.” (Paul, line 569)

Paul illustrates here the importance of informal peer support within the team, and implies that people who choose not to share their feelings with others in the team are unable to cope with the work.

In summary, participants cope with the difficult emotions associated with the work by switching off and detachment. It seems that there is a concern about asking for support and what that may mean about one’s perceived ability to cope, but most participants are aware that some form of support is needed in order to have the opportunity to express feelings which emerge in response to events or incidences on the ward. The most acceptable form of support seems to be informal peer support between colleagues.

DISCUSSION

Summary and Discussion of findings

The participants in this study described experiences of working with uncertainty and a lack of control, hopelessness and frustration due to feeling restricted, working in a threatening and frightening environment, increased emotional involvement with younger patients, hopefulness when working with people at the early stages of mental illness, and detachment and switching off in an attempt to cope.

The mental health nursing identity

Some of the experiences and concerns of the participants were inconsistent with Hurley's (2009) model of the mental health nursing identity; the idea of 'spending time with the service user' is incongruent with the current finding of participants feeling there is not enough time to spend with patients, and the 'service user focus' is felt to have given way to a focus on documentation and the management of risk. Also, 'delivering therapies' is not part of the role of a mental health nurse on an acute inpatient ward; staff feel that they are not providing any therapeutic interventions despite having a desire to do so. The frustrations expressed by some of the participants, related to the theme of feeling restricted, may stem from the conflict between the identity associated with the nursing role and the perceived obstacles to maintaining this when working in acute care. However, 'positioning and utilising the personal self' is consistent with the subtheme of feeling like a parent; some staff utilise their position as a parent to form attachments with patients, despite a felt need to detach from patients in order to cope with difficult feelings of frustration or guilt, related to the theme of coping and self-preservation.

Control, care and treatment

Bott (1976) described a conflict in psychiatric hospital care between control, care and treatment; the hospital is required to control the 'madness' which is felt by society to be unacceptable, to care for patients who require respite from their difficulties, and to offer them treatment or cure. These aims may be incompatible with each other, leading to conflict in making sense of the nursing role. Participants in this study did not directly express an awareness of these conflicts, but they did explore the difficulties of finding themselves managing patients who are "at their worst", whilst feeling restricted in the level of care and treatment they were able to offer due to the priorities imposed upon them by regulations related to safety, risk and documentation.

Risk of burnout

Not only can psychiatric hospitalisation be distressing for patients, but the work can be distressing for staff. Feelings of hopelessness, impotence and frustration were present in the stories of the participants. It is possible that these emotions along with the constant state of high arousal described by most participants could lead to emotional exhaustion. A perceived lack of ability to help some patients and a depletion of emotional resources may lead to the need for detachment, and these elements combined (emotional exhaustion, a sense of ineffectiveness and detachment) are important predictors of burnout (Maslach, 2003). When thinking particularly of younger patients who have been hospitalised for the first time participants expressed an increased level of hope, an increased emotional attachment to the patients, and an increased chance of accomplishment. Working with younger patients with early psychosis may therefore act as a protective aspect of the work for staff, decreasing their chances of burnout. However, a potential danger of this split (between the perceived hopelessness of, and emotional detachment from, the situations of more chronically ill patients and the hopeful, emotionally attached relationships with younger patients) is the depersonalisation and categorisation of patients who can or cannot be helped towards recovery, regardless of their individual differences.

Working with patients experiencing their first psychiatric hospital admission can be unsettling for staff due to the lack of available information, and having to tolerate uncertainty about a diagnosis. However this could be an advantage for the patients; staff may have fewer preconceptions and be more likely to respond to the patient as they present, rather than based on diagnoses, past admissions or previous documentation.

Social defence systems

Many participants described a sense that there is very little time or opportunity to think about and reflect on the work and the situations in which they find themselves. One interpretation of this would be that the feelings evoked by the work are avoided by staff in order to protect themselves from being overwhelmed, and that the system acts as a social defence to aid the detachment from and denial of unbearable feelings (Menzies, 1960). For example, the defensive structure of the system may mean that an increase in paperwork is unconsciously welcomed as a defence against the painful emotions associated with intimacy with patients and with the perceived inability to help some patients. A distance may then be created between staff and patients due to fear of these emotions. Participants in the study were able to describe how they consciously avoid thinking about the impact of the work by switching off, detaching and getting on with it.

Job satisfaction

Cahill (2004) proposed that although burnout is moderate in inpatient care, job satisfaction may be high, and that adequate social support contributes to job satisfaction. Many of the participants reported that, despite working in a restricted and distressing environment, they enjoyed their jobs. This may reflect a denial of distressing feelings associated with the work, but also this may be a reflection of the high level of peer support which is felt to be available.

Limitations of the study

The participants in this study were nine nursing staff from two inpatient units, and the results cannot be generalised to all staff or inpatient units. The area of interest was nurses' work with patients with early psychosis, but at times during the interviews participants broadened this focus to more general aspects of the work.

IPA aims to describe but not explain the experience of the participants, using their reported experiences to attempt to understand their reality rather than finding a 'truth', and the description provided here is based on the researcher's interpretations of the data. Validity checking was carried out in order to limit the potential bias of interpretation. My position as researcher but also as a trainee clinical psychologist on placement at a different acute inpatient unit means that I have had some experience of working on an acute admissions ward alongside nursing staff, but no experience of the nursing role or of the units which the participants worked on. My own role in inpatient care has meant that I have been exposed to the demands of working in a chaotic environment with patients who are acutely distressed, but I have not had personal experience of the day-to-day pressures of the nursing role; I have had the luxury of spending time with both patients and staff thinking together about their experiences, and of exploring my reflections on the work in supervision. During the interview process some participants may have assumed that the researcher was affiliated with early intervention services due to the focus on younger patients who had been hospitalised for the first time, and this may have influenced them to provide more positive accounts of their feelings towards working with younger patients. This study was part of a wider research project investigating the experiential impact of hospitalisation on patients, families and staff. Advantages of this included the availability of peer researchers for credibility checks and general support; however the links between the three studies also produced the challenge of presenting an analysis which focused on one part of the picture with an awareness of a wider context via my involvement with the other two studies.

Implications for practice and further research

Time spent with patients

Participants in this study described experiences of competing demands on their time and the reactive nature of the work, which has implications for how staff organise their time on the ward, the amount of time spent in direct contact with patients, how tasks are delegated and how the responsibility of minimising risk is managed. The amount of time spent with patients hospitalised for the first time may influence their levels of engagement. The NHS Institute for Innovation and Improvement (2008) have proposed a Productive Mental Health Ward programme. The benefits of implementing this programme are suggested to be "releasing time to care, improved quality of care, improved patients safety, improved staff morale, and the potential to make financial savings by eliminating waste and making processes more efficient" and an additional focus on "more meaningful and engaging therapeutic interventions with patients" (p. 1). Improvements following the implementation of this programme, including increases in direct care with patients and a reduction in sickness absence, have been reported in case studies (NHS Institute for Innovation and Improvement, 2009) but larger scale research is needed in order to explore the long term implementation and outcomes of the programme.

Support and supervision

The Department of Health mental health policy implementation guide on acute inpatient care provision (2002) states that “effective staff support, management and clinical supervision arrangements must be in place. These arrangements need to include follow-up support for staff involved in distressing or untoward incidents” (p. 19), and that “It is essential that staff have the opportunity to jointly reflect on the impact of the day to day work with users and their families in order to feel informed and empowered to make the most effective interventions”(p. 33).

Clinical Supervision may assist nurses in dealing with the impact of caring for acutely disturbed patients by helping them to think about their work and to explore and process difficult feelings about patients in a containing environment (Winship, 1995). Nurses in the acute setting are required to ‘hold’ the patients’ distress, and therefore need to be ‘held’ themselves (Winnicott, 1994). This sense of holding can be provided in clinical supervision. The improved containment of staff could increase their capacity to contain the patients and improve therapeutic relationships. A recent systematic review of clinical supervision in psychiatric nursing concluded that clinical supervision may be beneficial, but that studies in the existing research literature are small in scale, do not agree on a model of supervision, and do not use methods considered to provide valid and reliable research (Buus & Gonge, 2009). Further research is needed in order to provide empirical support for the use of clinical supervision in inpatient psychiatric nursing. In this study, some participants said that they currently received clinical supervision, some said that they did not, and some said that it was available but that they did not ask for it. Further research into the meaning of needing support and supervision to mental health nurses may help to determine how to encourage nurses to feel able to access clinical supervision and support in their work. Reflective practice groups for staff provide a space for openness, thoughtfulness and creative thinking (Evans 2006), however there is a lack of available research into their implementation and effectiveness, and further exploration is needed. All of the participants commented that they felt supported within the team, but that this support was informal and time was not set aside for it. Staff may benefit from formally arranged time for peer supervision groups. Research into the implementation and evaluation of this is required.

A systematic review of strategies to improve morale and reduce burnout among staff in psychiatric units concluded that there were potentially effective strategies such as “enhanced staff skill, staff support, supervision and psychological care” (p. 16), but that poor managerial support in their implementation has meant that they have failed to show an effect in some cases (Gilbody, Cahill, Barkham, Richards, Bee & Glanville, 2006). Further research into effectively implemented strategies to support acute inpatient nursing staff is needed.

Hope

A recent systematic review revealed that there is a paucity of research on the factors which contribute to hope in mental health nursing, and further research is needed (Cutliffe & Koehn, 2007). Landeen, Kirkpatrick, Woodside, Byrne, Bernardo & Pawlick (1996) investigated factors which influenced staff hopefulness in working with patients diagnosed with schizophrenia. They found that knowing clients as people, sharing client successes, and receiving recognition for their accomplishments were important to hopefulness. Inpatient nursing staff often do not have the opportunity to get to know patients well or to witness their recovery due to their contact with them occurring only in an acute phase of illness. Further research is needed into the factors which may inspire hope in inpatient nursing staff.

In conclusion, working in the acute inpatient environment involves exposure to high levels of disturbance in conditions which are unpredictable and restrictive, but working with younger patients experiencing their first admission may be associated with closer emotional attachments and increased hope for recovery. The findings and clinical implications of this study are based on a detailed analysis of the subjective experiences of a small sample of nursing staff, and larger scale research is needed to expand on these findings.

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APPENDIX I

Critical appraisal of study methodology using Sale and Brazil's (2004) criteria.

Quantitative Studies appraisal criteria	Ray & Myers (1996)	Meehan, Bergen & Fjeldsoe (2004)	Stolker, Nijman & Zwanikken (2006)	Steinert, Bergbauer, Schmid & Gerbhardt (2007)	Veltkamp, Nijman, Stolker, Frigge, Dries & Bowers (2008)	Keski-Valkama, Koivisto, Eronen & Kaltiala-Heino (2010)
Truth Value (internal validity)						
Extraneous or confounding variables identified	1	1	1	1	1	1
Extraneous or confounding variable(s) or baseline differences controlled for in the analysis	0	0	0	0	0	0
Statement about comparability of control group to intervention group at baseline	0	0	0	0	0	0
Statement that comparison group treated equally aside from intervention	0	0	0	0	0	0
Informed consent stated	1	1	1	1	1	1
Ethical review undertaken	1	1	1	1	1	1
Statement that confidentiality protected	1	0	0	0	0	0
Applicability (external validity/ generalizability)						
Statement of purpose	1	1	1	1	1	1
Objective of study explicitly stated or described	1	1	1	1	1	1
Description of intervention if appropriate	0	1	1	0	0	0
Outcome measure(s) defined	1	1	1	1	0	1
Assessment of outcome blinded	0	0	0	0	0	0
Description of setting or conditions under which data collected	1	1	1	1	1	1
Design stated explicitly (i.e. case study, cohort study, RCT)	0	1	0	0	0	1
Subject recruitment or sampling selection described	1	1	1	1	1	1

Inclusion and exclusion criteria for subject selection stated explicitly	0	1	1	1	1	1
Study population defined or described	1	1	1	1	1	1
Source of subjects stated (i.e. sampling frame identified)	1	1	1	1	1	1
Source of controls stated	0	0	0	0	0	0
Selection of controls described	0	0	0	0	0	0
Control or comparison group described	0	0	0	0	0	0
Statement about non-respondents or dropouts or deaths	0	0	1	1	1	1
Missing data addressed	0	0	0	0	0	0
Power calculation to assess adequacy of sample size or sample size calculated for adequate power	0	0	0	0	0	0
Statistical procedures referenced or described	0	1	1	1	1	1
P values stated	0	1	1	1	1	1
Confidence intervals given for main results	0	0	0	1	0	1
Data gathering procedures described	1	1	1	1	0	1
Data collection instruments or source of data described	1	1	1	1	0	1
At least one hypothesis stated	0	0	1	1	0	0
Both statistical and clinical significance acknowledged	1	1	1	1	1	1
Consistency (reliability)						
Standardisation of observers	0	0	0	0	0	0
Total:	14 (45%)	18 (58%)	19 (61%)	19 (61%)	14 (45%)	19 (61%)

Qualitative Studies appraisal criteria	**Meehan, Vermeer & Windsor (2000)**	**Hoekstra, Lendermeijer & Jansen (2004)**	**Holmes, Kennedy & Perron (2004)**	**Mayers, Keet, Winkler & Flisher (2010)**
Truth Value (credibility)				
Triangulation of sources	0	0	0	0
Triangulation of investigators	0	0	0	0
Triangulation of theory/ perspective	0	0	0	0
Peer debriefing	0	0	0	0

Negative case analysis or searching for disconfirming evidence	0	0	0	0
Member checks	1	0	0	0
Use of quotations	1	1	1	1
Informed consent stated	1	1	1	0
Ethical review or human subject review undertaken	0	1	0	1
Statement that confidentiality protected	0	0	1	1
Consent procedures described	0	1	1	0
Applicability (transferability / fittingness)				
Statement of purpose	1	1	1	1
Statement of research question(s)	1	1	1	1
Phenomenon of study stated	1	1	1	1
Rationale for the use of qualitative methods	1	1	1	1
Rationale for the tradition within qualitative methods	0	1	1	0
Description of study context or setting	1	1	1	1
Statement of how setting was selected	0	1	1	0
Sampling procedure described	1	1	1	1
Justification or rationale for sampling strategy	1	1	1	1
Description of participants or informants	1	1	1	1
Data gathering procedures described	1	1	1	1
Audiotaping procedures described	1	1	1	1
Transcription procedures described	1	1	1	1
Field note procedures described	0	0	0	0
Data analysis described	1	1	1	1
Coding techniques described	1	1	1	0
Data collection to saturation specified	0	1	0	0
Statement that reflexive journals or logbooks kept	0	0	0	0
Description of raw data	0	0	0	0
Consistency (dependability)				
External audit of process	0	0	0	0

Neutrality (confirmability)				
External audit of data and reconstructions of the data	0	0	0	0
Bracketing	0	0	0	0
Statement of researcher's assumptions or statement of researcher's perspective	0	0	1	1
Total	16 (47%)	20 (59%)	20 (59%)	16 (47%)

Mixed method Studies appraisal criteria - Quantitative	**Martinez, Grimm & Adamson (1999)**	**El-Badri & Mellsop (2008)**	**Roberts, Crompton, Milligan & Groves (2009)**
Truth Value (internal validity)			
Extraneous or confounding variables identified	1	0	0
Extraneous or confounding variable(s) or baseline differences controlled for in the analysis	0	0	0
Statement about comparability of control group to intervention group at baseline	0	0	0
Statement that comparison group treated equally aside from intervention	0	0	0
Informed consent stated	1	0	0
Ethical review undertaken	0	0	1
Statement that confidentiality protected	1	0	0
Applicability (external validity/ generalizability)			
Statement of purpose	1	1	1
Objective of study explicitly stated or described	1	1	1
Description of intervention if appropriate	0	1	1
Outcome measure(s) defined	1	1	1
Assessment of outcome blinded	0	0	0
Description of setting or conditions under which data collected	1	1	1

Design stated explicitly (i.e. case study, cohort study, RCT)	0	0	0
Subject recruitment or sampling selection described	1	1	0
Inclusion and exclusion criteria for subject selection stated explicitly	0	0	0
Study population defined or described	1	1	1
Source of subjects stated (i.e. sampling frame identified)	1	1	0
Source of controls stated	0	0	0
Selection of controls described	0	0	0
Control or comparison group described	0	0	0
Statement about non-respondents or dropouts or deaths	0	0	0
Missing data addressed	0	0	0
Power calculation to assess adequacy of sample size or sample size calculated for adequate power	0	0	0
Statistical procedures referenced or described	0	0	0
P values stated	0	0	0
Confidence intervals given for main results	0	0	0
Data gathering procedures described	1	1	1
Data collection instruments or source of data described	1	1	1
At least one hypothesis stated	0	0	0
Both statistical and clinical significance acknowledged	1	1	1
Consistency (reliability)			
Standardisation of observers	0	0	0
Total:	13 (42%)	11 (35%)	10 (32%)

Mixed method Studies appraisal criteria – Qualitative	**Martinez, Grimm & Adamson (1999)**	**El-Badri & Mellsop (2008)**	**Roberts, Crompton, Milligan & Groves (2009)**
Truth Value (credibility)			
Triangulation of sources	0	0	0
Triangulation of investigators	0	0	0
Triangulation of theory/ perspective	0	0	0
Peer debriefing	0	0	0
Negative case analysis or searching for disconfirming evidence	0	0	0
Member checks	1	0	0
Use of quotations	1	1	1
Informed consent stated	1	0	0
Ethical review or human subject review undertaken	0	1	1
Statement that confidentiality protected	1	0	0
Consent procedures described	1	0	0
Applicability (transferability / fittingness)			
Statement of purpose	1	1	1
Statement of research question(s)	1	1	1
Phenomenon of study stated	1	1	1
Rationale for the use of qualitative methods	0	0	0
Rationale for the tradition within qualitative methods	0	0	0
Description of study context or setting	1	1	1
Statement of how setting was selected	0	0	0
Sampling procedure described	1	1	0
Justification or rationale for sampling strategy	0	0	0
Description of participants or informants	1	1	0
Data gathering procedures described	1	1	1
Audiotaping procedures described	0	0	0
Transcription procedures described	0	0	0

Field note procedures described	0	0	0
Data analysis described	0	1	1
Coding techniques described	0	0	0
Data collection to saturation specified	0	0	0
Statement that reflexive journals or logbooks kept	0	0	0
Description of raw data	0	0	0
Consistency (dependability)			
External audit of process	0	0	0
Neutrality (confirmability)			
External audit of data and reconstructions of the data	0	0	0
Bracketing	0	0	0
Statement of researcher's assumptions or statement of researcher's perspective	1	0	0
Total	13 (38%)	9 (26%)	8 (24%)
Total Quantitative & Qualitative criteria met	26 (40%)	20 (31%)	18 (28%)

APPENDIX II

Copy of ethical approval letter

(removed from e-thesis copy for protection of personal data)

APPENDIX III

UNIVERSITY OF BIRMINGHAM

PARTICIPANT INFORMATION SHEET

Title of Project: The experience of hospitalisation in early psychosis

Researcher: Jessica Colin, University of Birmingham.

The current research project is being undertaken as part of a Doctorate in Clinical Psychology at the University of Birmingham.

This study will involve interviewing inpatient staff members who have worked with young people who have been hospitalised due to their psychosis, whilst under the care of the Early Intervention Services (EIS). Early Intervention Services aim to keep people out of hospital, and to enable recovery by other means. We know that psychiatric hospitalisation can be distressing for the person who is hospitalised, but little is known about the impact of the hospitalisation on the staff members. Furthermore, little is known about the impact of hospitalisation in the context of services where young people are often hospitalised in a crisis, and probably for the first time, and may have thought that this was unlikely to happen.

The aim of this research is therefore to spend some time asking staff members about their experiences of working on an inpatient ward in order to establish what impact this type of work has on them, what they find helpful and /or unhelpful, and to learn more about staff members' experiences of the work.

- **What is the purpose of this research?**

The purpose of this research is to establish:

1) What are staff members' experiences of caring for individuals with an early psychosis on an inpatient unit?
2) What did staff find helpful and / or unhelpful when caring for the individuals?
3) What are staff members' experiences of stress when caring for individuals with an early psychosis on an inpatient unit?

- **Why have I been invited to take part?**

You have been invited to take part in this research because you have been identified as a member of staff on an inpatient unit who has cared for an individual with an early psychosis in the last 12 months.

- **What will happen to me if I agree to take part?**

All that will be asked of you is that you give approximately 90 minutes of your time to talk to a researcher about your experience. Your participation will be anonymous and your identity will not be stored with your comments. Your responses will be given a code number and the list containing this number with your name will be kept safely and then destroyed once all the data have been analysed. Some of your responses ‘word-for-word’ will be put into a written report but anything that you say will remain anonymous.

- **What will happen if I do not want to carry on with the study?**

Your participation in this research is completely voluntary. You are free to withdraw from the research study at any stage without giving a reason. Following your interview you will have up to one month to withdraw your consent for your interview data to be analysed.

- **Expenses and payments**

Your participation in this research is voluntary. Although there are no direct benefits for participants it is hoped that there will be a value to discussing your experiences. It is also hoped that the outcome of the research will help to develop better services for people experiencing an early psychosis, their families, and staff.

- **What will happen to the results of the research study?**

On completion of the research study the responses gathered from all participants will be analysed and written up for publication. Please indicate on the consent form if you would like an accessible copy of the research findings upon completion.

- **What happens if I have any further concerns?**

This information sheet is yours to keep, if you have any further concerns please contact any member of the research team (all details below).

If you would like to discuss any aspect of this research please contact:

Researcher	**Academic Supervisor**
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APPENDIX IV

UNIVERSITY OF BIRMINGHAM

CONSENT FORM

Research site:
Participant Identification Number:

Title of Project: The experience of hospitalisation in early psychosis
Researcher: Jessica Colin

Please initial box

1. I confirm that I have understood the information sheet (Version 2 09/04/10) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected. ☐
3. I understand that the research interview will be audio-recorded. ☐
4. I understand that following the research interview I will have a four-week period for reflection. Up until this point I may withdraw my interview entirely or in part, without giving any reason. ☐
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. ☐
6. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that all efforts will be made to ensure that I will not be identifiable by my comments. ☐
7. I agree to take part in the above study. ☐

....	....	....
Name of participant	Date	Signature
....	....	....
Name of researcher	Date	Signature

APPENDIX V

INTERVIEW SCHEDULE

1. Can you tell me about how you came to work in the inpatient unit?
    - When did you start?
    - What drew you to the job?
    - What were your expectations?
    - What was it like then?
    - How have things changed in that time?
    - What's the best thing about working here?
    - What's the most challenging part of your job?

YOUNG PEOPLE'S EXPERIENCES ON THE UNIT

2. Can you describe what the unit is like for the younger people who find themselves here?
    - We're particularly thinking of Early Intervention clients, and of younger people who might be in hospital for the first time
    - How do they react when they arrive?
    - What sorts of things do the younger patients do while they are here?
    - What sorts of things do they do with the staff here?
    - How do they interact with other patients on the unit?
    - Who visits them?
    - How do the young people interact with their visitors?
    - How do their visitors react, when they come here?
    - How do the young people seem when they are discharged?

3. If you knew a young person who was going to be coming here, what would you tell them and their family about it?

YOUR EXPERIENCE OF WORKING WITH YOUNG PEOPLE ON THE UNIT

4. How do you find it, working with the younger people on the unit? [Prompt for examples]

    - What sorts of things do you do with them?
    - Are there any particular challenges for you, that you'd particularly associate with working with the younger patients?
    - How do you cope with those?
    - What kinds of support are available to you?
    - Are there any particular rewards, that you'd particularly associate with working with the younger patients?

5. If you knew a colleague was thinking of transferring in to work on the unit, what would you tell them about it?

6. If you could change one thing about this unit, what would it be?

APPENDIX VI

Extract from a coded transcript to demonstrate descriptive line-by-line coding, identifying the objects of concern and experiential claims of the participant.

Objects of concern	**Extract**	**Experiential claims**
What the ward is like for younger patients	*165-167 frightening, very frightening, erm, it must be frightening to, for them to be here in the first place, obviously whether they've got a psychosis, depression, whatever*	Frightening x3 -to come here as well as to have psychosis
First impressions of the ward	*167-170 but then to have to, if I step back to how I felt when I first walked in to a psychiatric ward I thought "oh my god", because it is, it's a real eye-opener, and it must be for them as well*	Based on my experience – eye-opener
The ward	*170-171 it must be a frightening and intimidating sort of place to be, very difficult, yeah.*	Frightening and intimidating
The ward for younger people	*173-177 most of them don't want to stay, most of them are frightened by what they see, er they see other patients shouting, patients who, psychiatric conditions who have got mixed behaviours, who dress inappropriately, look odd, you know, I think a lot of the younger psychiatric patients erm, they feel quite upset by what they see.*	Want to leave See other patients Upset
Activities	*180-183 we've got activity workers, who you know, every day they set out a group or activities, and they try to get as many of the patients involved as possible, and certainly the youngest ones we would want them involved in that*	Try to involve younger people in activities
Isolation	*183-189 we don't want them being locked away, isolated in their room, it depends, you know, how unwell they are...you know it's not fair to ask someone to do something if they're, you know paranoid or you know too frightened to, or can't concentrate long enough.*	Don't want them to be isolated Sometimes unable to take part in activities due to paranoia or difficulty concentrating
Family	*189-194 we try and get the patients to sort of become erm, make sure that they keep their link with their family as well, that's important, we want them to come in as often you know as they see, see fit, I know we're supposed to have visiting times but for younger people maybe, we, in the past we have sort of made allowances for that.*	Keep links with family – important for younger people Make allowances for younger people – break the rules so they can see family more
Activities	*196-200 we just try and keep them as normal as possible, just try and, you know, discussions and things, get them to, magazines, the things that they want, we are a bit limited in what we can do because obviously, you know the staff there are only five staff to cater for the whole patient group*	As 'normal' as possible Things they like to do Staff are limited due to numbers
Interventions	*202-207 there's no sort of specific interventions, for younger people, erm, there's other things that go on as well which will go on with all the other patients, like they would have occupational health, er, oh I'm sorry occupational therapy, erm assessments, things like that going on, to see you know how they are, what their skills are like.*	No specific intervention for young people – same as other patients OT assessment of skills
Staff time with patients	*209-212 quite often one of the staff will sit and talk to them, about their feelings and, erm, that's quite a big thing you know, just being able to listen, let them ventilate their feelings, their fears, their anxieties*	Sit and talk about feelings Ventilate feelings, fears, anxieties
Parenting patients	*212-214 the staff sometimes with the younger people as well, to be a bit of a sort of role model as well that can be quite important for them*	Parental role of staff – role model for younger people

Role models	*216-220 sadly some of the people that come in haven't had any role models, I can think of a few patients like that who have had, you know, what you would describe as dreadful childhoods, and er, well no childhood at all to speak of so, yeah that's important as well, to try and be a role model to them, er, on the ward*	Some patients haven't had role models – sad Dreadful childhood/ no childhood Important – young people need role models
Staff time with patients	*220-230 like I say play we games or whatever if they want to do that, table tennis, take them for walks, erm, but as, like I say it's about what you can do for them...and you've got to bear in mind that a lot of people that I see, it's an acute admissions ward, a lot of people aren't up for that sort of thing, and when they start being up for it we should really be looking at, you know, when they're ready to move them on, but yeah, give them psychological support, when we're there, you know.*	Play games, walks Limits to what staff can do / limits to what the patients can do Acute admission – not up for doing things – when they are they move on Give support when we can
Time with younger patients	*233-236 it can be quite, erm, challenging, you know, you, they see you as an older person, you know, as all young people do, you know, "old git", you know, "what does he know about anything?", so yeah, you can get that sort of experience*	Challenging – perceived as old / not knowing anything
Engaging younger patients	*237-244 there's obviously like things that they talk about, unfortunately a lot of the young people come in, you know, they do drugs, alcohol, things like that, you know, and it can be difficult to engage with them because, like I say they see you as some, you know, older person, non-entity, you know, "why would I want to sit and talk to you about what goes on in my life?"...so that can be challenging on its own*	Difficult to engage when talking about drugs and alcohol Non-entity - seen as nothing Don't want to talk to us Challenging
Engaging younger patients	*244-247 we talk, try and, generally talk to them about their interests and, you know I get them to, just talk to them about how they feel about things get their confidence, you know, so yeah, it can be difficult.*	Talk about interests, feelings, confidence – difficult
Hearing patients' histories	*252-261 It's dreadful, sad...we had someone in not so long ago, and erm, er, the whole thing was, he was quite unwell, and obviously it seemed quite obvious to me that he'd, developing schizophrenia, and er, the whole thing was terrible, you could see that the family, you know they didn't mention the word schizophrenia or, you know, severe mental illness but they were obviously really erm worried about it and all the rest of it you know it, seeing their fears realised it's awful, it's not nice.*	Dreadful and sad to hear patients' histories Terrible to see the family worried Awful, not nice to see families have their fears realised
Younger patients	*263-267 This young person should have their whole life in front of them, and not to be kind of stuck in here you know, and quite often, you can, I mean you can't predict everyone, but you can, if you see enough people you know sometimes how debilitating their illness is going to be and you think how sad that's going to be*	Young – whole life in front of them – taken away - a waste? Sometimes you can predict life-long illness & that's sad
Effects on family	*270-276 there's a couple I can think of yeah, who are, I think, you know that's, they're going to live a difficult life, you know, and the family, like I say seeing it dawning on them, what's happened, and you know quite often with families you know that they're terrified and they know something's seriously wrong and they don't want you to use the kind of terminology that ends up being used. Yeah, it's sad. it's sad.*	Can see people and know their lives will be difficult See realisation in family – terrified Use of terminology makes it worse Sad x2
Patients interactions	*279-285 Again, it can depend, some, some young people, we were actually talking about this this morning, totally unrelated to this... and we were talking about how some people come on the ward and they fit right in, they you know erm, they get on fine with the other patients, they enjoy their company, it can, quite often there's an individual thing*	Individuality of patients – not predictable Some get on fine

APPENDIX VII

Extract from final table of themes, showing one theme across transcripts, to demonstrate identifying themes across transcripts and developing a structure.

Superordinate Theme	Participants contributing to theme	Subthemes	Participants contributing to subtheme & Key cross-references	Indicative Quotes
Working with Uncertainty	All	Individuality of patients	Sally (L32, L440, L498, L622) Janet (L120, L149, L179 L311, L339) Paul (L282) Sue (L130, L300) Rachel (L157, L241, L286) Linda (L52, L309, L317)	"Some people can be withdrawn, some people can, as soon as they come on the ward some people can be quite violent, we have to deal with each situation that comes up really, you know, some people react differently, erm, [PAUSE] some, just each situation, each person is diff-, totally different." (Sue, L130)
		Unpredictability of the working day	Sally (L522, L537) Heather (L164, L186, L534) Jill (L78, L638) Rachel (L279, L386)	"I suppose I, I did expect it to be a lot more about you know, you would be spending time helping people, talking to them, offering interventions, offering sort of you know therapies, but a lot of the time it's not about that it's about crisis management, you lurch from one crisis to the next and, and you manage that as it happens" (Jill, 78)
		Changing patient group	Sally (L540) Karen (L148) Linda (L254)	"I mean I could come in tomorrow and there could be ten new, different patients I've never met before, and they could be gone the next time I come on, so it's different, it's different all the time, it's a different challenge every day". (Sally, L540)