

**The Experiences of staff working in secure forensic child and adolescent mental health services: Exploratory interviews.**

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## Thesis Abstract

**Purpose:** The needs of young people within forensic mental health settings are starting to become more recognised and services are beginning to reflect this. However there is little research into how staff in forensic child and adolescent mental health settings experience the task of working with this group of young people with complex difficulties. The purpose of this study is to explore how these staff experience their work. This is intended to expand research in this area and identify how the findings can inform clinical practice and future research.

**Method:** A systematic literature search identified some research in relation to the needs of adolescents with mental health and forensic difficulties and literature in relation to working with children. Very little was found in relation to staff experiences working with children in forensic mental health settings but some research relating to adult forensic and mental health settings was found. A qualitative study was carried out in order to bridge this gap in the research. Interpretative Phenomenological Analysis was selected as the method of analysis for the study, which involved interviews with nine participants who were currently working in secure child and adolescent forensic mental health services.

**Results:** Four themes emerged from the first level of analysis: powerful internal experiences, impact of the environment, negotiating complex staff relationships and managing complex client dynamics. A second level of analysis focusing on the researcher's impressions of the research overall identified another theme: difficulty thinking about and articulating experiences.

**Conclusion:** This study is an important first step in identifying some of the issues faced by staff working in a challenging area. It has highlighted clinical implications and where further research might be useful.

### **Acknowledgements**

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### **Word Counts**

	Without references	With references
Thesis abstract	278	n/a
Literature review	7749	9420
Research Report	13424	14718
Critical Appraisal	3722	3973
Total	23173	28111

## **List of Contents**

<b>Thesis Abstract</b>	<b>2</b>
<b>Acknowledgements</b>	<b>3</b>
<b>Word Counts</b>	<b>4</b>
<b>List of Tables</b>	<b>8</b>
<b>List of Figures</b>	<b>9</b>
<b>Part One: Literature Review</b>	<b>9</b>
Abstract	10
1. Introduction	11
1.1 The Historical and Current Context of In-patient Mental Health Services	11
1.2 Ward Environment and the Research Context	12
1.3 Conceptualisation of Ward Atmosphere	14
2. Aims of the Literature Review	15
3. Methodology	16
3.1 Search Strategy and Search Terms	16
3.2 Inclusion Criteria and Search Results	16
4. Findings	17
4.1 Overview of Findings from Studies Using Quantitative Research Designs	17
4.2 Appraisal of Quantitative Research Designs	27
4.3 Overview of Findings from Studies Using Qualitative Research Designs	30
4.4 Appraisal of Qualitative Research Designs	34
5. Conclusions and Implications for Future Research	35
6. References	39
<b>Part Two: Research Report</b>	<b>48</b>
Abstract	49
1. Introduction	50
1.1 Adolescent Mental Health, Offending and Secure Services	50
1.2 Current Provision of Care	51
1.3 Specific Issues of Working with Young People with Complex Needs	51
1.4 General Issues of Working in Forensic and Mental Health Settings	52
1.5 Summary	54
1.6 The Current Research Study	54
2. Method	55
Overall Design of the Study	55
Ethical Approval	55
Epistemology and Choice of Method	56

Participants	58
Development of the Interview Schedule	59
3. Results and Analysis	64
3.1 First Level of Analysis	64
3.2 Second Level of Analysis	84
4. Discussion	95
4.1 Interpretation of Results	95
4.2 Methodological Issues	103
4.3 Clinical Implications	104
4.4 Conclusions	105
References	107
<b>Part Three: Critical Appraisal</b>	<b>117</b>
1. Choice of Research project	118
2. Development of Methodology and Design	120
3. Conducting the Research	122
4. The Interview Process	122
5. Engaging with the Research	124
5.1 Engagement during the Analysis	125
5.2 Supervision and Reflection	125
5.3 Impact of External Events and Personal Experiences	126
6. Writing Up	128
7. Conclusions and Learning Points	129
7.1 Being Prepared for the Unexpected	129
7.2 Relationship with Research	130
7.3 Research Skills	130
References	131
<b>Appendices</b>	<b>132</b>
Appendix A: Research Ethics Approval Letter	133
Appendix B: Ethics Letter Approving Change of Methodology	137
Appendix C: Participant Information Sheet	140
Appendix D: Interview Schedule	144
Appendix E: Participant Consent Form	146
Appendix F: Notes for Authors for Selected Journal	148

## **Addenda**

Addendum: A Separately Bound Volume of the Interview Transcripts

## **List of Tables**

Table 1: Search terms and databases used in the systematic literature search	17
Table 2: Description of the WAS	18
Table 3: Characteristics of staff participants from unit Y and unit Z	59

## **List of Figures**

Figure 1: The final representation of clustered themes	66
Figure 2: Themes within the second level of analysis	88

## **PART ONE: LITERATURE REVIEW.**

Optimal research designs for understanding the impact of ward atmosphere on staff  
and patients in in-patient mental health settings: A review of the literature

Word count: 7749

## Literature Review Abstract

**Purpose:** To provide an overview of the research findings in relation to ward atmosphere for staff and patients and appraise different research designs. The practical implications of different designs are considered and optimal designs for future research in this area identified.

**Method:** A systematic search of electronic databases was undertaken followed by a hand search for a select number of relevant articles. Literature focusing upon the perceptions of staff and patients about ward atmosphere or ward environment within in-patient health settings was prioritised.

**Results:** Quantitative research is most frequently carried out in this area, and this has shown that ward atmosphere as measured by questionnaire-based methods has a significant impact on staff and patient wellbeing. There are differences between these groups in terms of how they perceive the ward atmosphere but both groups can benefit from certain ward atmosphere factors such as order and organisation and support. Qualitative methods have allowed for more exploration of unconscious processes and ward culture as well as offering a way of accessing all individuals on a ward and avoiding reliance on fixed potentially outdated measures.

**Conclusions:** Both quantitative and qualitative research methods are required in order to effectively understand how the ward atmosphere is perceived and impacts upon staff and patients. More ways of involving marginalised patients in research is crucial in order to reflect the current social and political context.

Key words: ward atmosphere, ward environment, staff, patients, in-patient mental health settings.

Target Journal: Criminal Behaviour and Mental Health

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## **1. Introduction**

### **1.1 The Historical and Current Context of In-patient Mental Health Services**

The question of how society manages people with mental health problems is an issue of significant concern and ongoing debate in Britain and worldwide. It has been suggested that the rise of interest in and enthusiasm for care in the community in recent years has led to the quality of care in in-patient acute wards to suffer (Beadsmore et al., 1998). Recent attention in the UK has focused on issues such as the potential risk posed by patients to the general public and the safety and care of individuals placed in secure settings. This has been largely fuelled by high profile negative cases being reported in the media. Questions have been asked about the quality of in-patient mental health provision in Britain and there have been some scathing criticisms of these services. One example was a channel four undercover television documentary about psychiatric wards in 2006 entitled ‘Britain’s mental health scandal’ in which an undercover reporter exposed three NHS acute trusts as lacking resources, having understaffed wards, and being “chaotic, frightening and dangerous”.

A publication providing guidance for the provision of adult acute care stated that there was “incontravertible and compelling evidence” that service users find hospital care ‘neither safe nor therapeutic’ (DoH, 2002). More recently a review of NHS acute in-patient services recognised there was a need for improvements including more personalised care for patients, guaranteed safety of patients and carers and provision of appropriate and safe interventions (Commission for Healthcare Audit and Inspection 2008). This review found that 39 percent of trusts were scored ‘weak’ on involving service users and family members in their care. It would appear that there

are significant shortcomings in relation to in-patient mental health provision in the UK, posing a challenge to the government and society in general.

Significant developments have taken place in the last two centuries in terms of providing care to people who require in-patient mental health facilities. At one time people deemed to have mental illness would have been removed from society and placed in an asylum with little hope of treatment or rehabilitation. Medical and surgical advances, the growth of psychotherapeutic approaches and cultural and ideological changes in how society treats people with psychiatric diagnoses have made recovery and returning to society realistic goals for the majority of patients. In addition to the development of specific treatment approaches, the idea of the environment within which patients are placed and the degree to which it is therapeutic has achieved more attention.

## **1.2 Ward Environment and the Research Context**

As early as the 1800s the idea of ‘milieu therapy’ was being pioneered as an alternative humane treatment approach to asylums. A therapeutic milieu represents a specialised environment which is designed to fulfil the general purposes of preventing “bad” things from happening and allowing “good” things to occur (Gunderson, 1978, p.332). Gunderson identified five functions which characterised therapeutic milieu as containment, support, structure, involvement and validation. Therapeutic communities, based on related principles, emerged towards the end of the second world-war under the leadership of Maxwell Jones (Rice et al., 1992). The therapeutic community mode of treatment became a popular mode of treatment as an alternative to traditional methods. According to Peplau (1978) the interest in the milieu during

the 1950s may have arisen as a reaction against prevailing environments, particularly mental health hospitals. However Peplau (1978) highlighted that despite initial claims about the benefits of milieu it had since lost some of its popularity, possibly due to claims about the new approach not being realised within a reasonable amount of time. This fits with a historic notable lack of scientifically rigorous research regarding therapeutic community treatment approaches (Lees et al., 2004). However the work of Peplau (1978) continued to highlight the importance of “creating atmospheres conducive to recovery” (p76), in particular within the field of psychiatric nursing, and a recent meta analysis has provided support for therapeutic community treatment approaches (Lees et al, 2004).

Therapeutic Communities could be seen as occupying a place at one end of the spectrum in respect of the significance placed upon the therapeutic environment as the primary mode of treatment. However there is a general recognition that the treatment environment is an important factor in relation to in-patient care even where there are additional treatments available. Fluctuations in research regarding ward environment have been evident over time. The first large scale study of ward atmosphere emerged in the 1960s (Moos and Houts, 1968) and there was an increase in this type of research in the late 1990s. It is likely that this pattern reflected changes in the social and political context at these times such as the move away from institutions in the 1960s and the increased focus upon recovery and the move towards community based care in the 1990s. However despite the increased recent focus upon the standards of care within in-patient settings, there still appears to be a paucity of British research into the ward environment of in-patient settings. Many of the recent studies have taken place in Scandinavian countries. As stated by Norton (2004) therapeutic milieu

research has become more difficult but arguably, of greater importance due to its relative scarcity. He highlighted that in the 21st century the environment of inpatient wards is different to that of the 1960s or 1970s to which the majority of therapeutic milieu research relates. The average length of patients' stay is reduced, the proportion of detained and psychotic patients is higher and the risk of violence is greater. These factors alone suggest that an emphasis on the therapeutic environment is as important as it has ever been.

### **1.3 Conceptualisation of Ward Atmosphere**

Previous studies have found the ward environment to be an important factor both in relation to psychiatric patient treatment (Ellsworth et al., 1971; Spiegel & Younger, 1972; Timko & Moos, 1998). In addition it has been found that the environment also has an impact on staff wellbeing outcomes (Moos & Schaefer, 1987; Blegen, 1993; Revicki & May, 1989; Lucas et al., 1993; Parkes & Von Rabenau, 1993). Moos (1968) stated that in general, ward settings have differential effects on patients and staff and have the tendency to elicit a particular hierarchy of reactions regardless of the individuals involved. Therefore the ward environment is an important independent factor to be considered within in-patient settings as it has the potential to impact not only upon patients' wellbeing and progress but also on how staff members perform the role of caring for them. This clearly has implications in a variety of settings and is a significant issue in the current political context.

In terms of conceptualising the dynamic features of in-patient wards, terms such as 'social climate' and 'ward atmosphere' have been used interchangeably in the literature to describe the same concepts. In the last 50 years the concept of 'ward

atmosphere' has emerged in the literature as a dominant term to describe and measure the 'personality' of a specific ward. This appears to have emerged primarily from the work of Moos and Houts (1968). They introduced a process of comparing wards without having to rely on observable indexes such as number of staff, open or locked doors and the presence of processes such as community meetings. Moos (1974a) later carried out an extensive study measuring different aspects of a ward environment, which were identified as contributing to the personality or atmosphere on a ward. The Ward Atmosphere Scale (WAS: Moos, 1974b) was developed from this study, made up of three dimensions; relationships, personal growth and system maintenance. These three scales were considered to incorporate the salient factors of ward atmosphere. For the purposes of this review, the term ward atmosphere will be used not only to describe the factors identified by Moos (1974b) but to describe characteristics of wards more generally.

## **2. Aims of the Literature Review**

Despite the fact that ward atmosphere is a concept that has been measured for over 50 years it is still difficult to grasp and investigate what it actually means (Brunt & Rask, 2007). A number of different research approaches have been utilised by researchers attempting to understand how the atmosphere of a ward impacted upon patients and staff. This review aims to:

- Provide an overview of the findings from research in this area in relation to staff and patient outcomes
- Appraise different research designs
- Consider the implications of different research designs in practice
- Identify optimal designs for future research in this area

### **3. Methodology**

#### **3.1 Search Strategy and Search Terms**

References were obtained by an electronic systematic literature search in the first instance. The search terms and databases used are highlighted in table 1. In addition, key papers were reviewed for references, which appeared to be relevant to the current literature review. Hand searching was kept to a minimum as the research in this area is published in a large number of different journals. However a small number of articles recommended by professionals familiar with the area of research were accessed by hand from relevant journals.

#### **3.2 Inclusion Criteria and Search Results**

Studies specifically exploring a range of ward atmosphere factors using staff and / or patients in in-patient mental health setting were prioritised as relevant to the current study. These were largely quantitative in nature. However a number of relevant qualitative papers were also included on the basis that they occurred within the context of interest. In-patient mental health settings as the context of this review included a range of mental health settings and included both forensic and non-forensic settings. Studies which only explored the relationship between patient symptomology and ward atmosphere were excluded on the basis of being too specific. Research studies focusing specifically on atmosphere factors in relation to prison settings were not included in this review. A substantial proportion of relevant research had been carried out abroad and published in international journals. Those not published in English were excluded. The search identified 31 appropriate published articles for review, examining factors associated with ward atmosphere for staff or patients within

mental health settings. One literature review was included and several research studies are referred to within the review but are not reviewed in detail.

**Table 1. Search terms and databases used in the systematic literature search**

<b><u>SEARCH TERMS</u></b>	<b><u>DATABASES</u></b>	<b><u>YEARS</u></b>
Ward atmosphere <b>OR</b> ward environment <b>&amp;</b> Mental health	EBSCO (PsychInfo and PsyArticles) and SCOPUS	All years available
Ward atmosphere <b>OR</b> ward environment <b>&amp;</b> staff	EBSCO (PsychInfo and PsyArticles) and SCOPUS	All years available
Ward atmosphere <b>OR</b> ward environment <b>&amp;</b> patients	EBSCO (PsychInfo and PsyArticles) and SCOPUS	All years available
Ward climate <b>OR</b> Social climate <b>&amp;</b> mental health	EBSCO (PsychInfo and PsyArticles) and SCOPUS	All years available
Ward atmosphere, mental health <b>&amp;</b> ward atmosphere, in-patient	Google Scholar	N/A
Ward environment, mental health <b>&amp;</b> Ward environment, in-patient	Google Scholar	N/A

## **4. Findings**

### **4.1 Overview of Findings from Studies using Quantitative Research Designs**

The majority of quantitative studies carried out to explore ward atmosphere have utilised the WAS (Moos, 1974b). Because of this the three dimensions which make up the WAS and a brief description of each is shown in Table 2. The WAS contains 100 items and respondents are asked to rate a series of statements about the ward atmosphere as true or false. It can be used for staff and patients and allows for rating the actual atmosphere and the ideal atmosphere. Previous research has utilised the WAS to compare ideal and ‘real’ ratings, to compare staff and patient ratings and to identify links between ratings of ward atmosphere and staff and patient outcomes.

**Table 2. Description of WAS Subscales (Moos, 1974b; 1996)**

<b><u>Subscale</u></b>	<b><u>Description</u></b>
<i>Relationship dimensions</i> 1. Involvement 2. Support 3. Spontaneity	How active patients are in the programme Support between patients and from staff to patients How much open expression of feelings is encouraged
<i>Personal growth dimensions</i> 4. Autonomy 5. Practical orientation 6. Personal problem orientation 7. Anger and aggression	How independent patients are in decision making Practical skills and preparation for release The extent to which patients seek to understand their problems Extent of staff and patients arguing / displaying anger
<i>System maintenance dimensions</i> 8. Order and organisation 9. Programme clarity 10. Staff control	How important order and organisation are Explicitness of rules and procedures Extent to which measures of control are used

#### **4.1.1 Summary of findings in relation to staff**

A small number of quantitative studies using the WAS have investigated the relationship between ratings of ward atmosphere and staff wellbeing. However due to the multitude of factors which might impact upon ward atmosphere such as staff roles, staff characteristics and ward function the picture is a complex one. By considering studies of ward atmosphere and other research regarding staff wellbeing in in-patient settings it is possible to identify some features of the ward environment, which are likely to have a significant impact on staff.

Job satisfaction and aspects of ward atmosphere appear to be linked. Dorr et al. (1980) examined the relationship between job satisfaction and perceived ward atmosphere.

They found that the aspects of the ward atmosphere which were most related to nurses

job satisfaction were order and organisation and programme clarity (both subscales of the system maintenance dimension) and practical orientation (personal growth dimension). This suggested that nurses valued a ward that ran smoothly, and the achievement of therapeutic goals for patients had a positive effect on their job satisfaction. It has been found that meeting the basic needs of staff can have a positive effect not only on them but also on their work with patients, in particular greater wellbeing, job satisfaction, less controlling attitudes towards patients and positive attitudes towards treatment (Lynch et al., 2005).

Job role, individual attitudes and level of education appears to have an impact on how staff perceive the ward atmosphere. Caldwell et al. (2006) explored the relationship between ward atmosphere and staff burnout for nursing and non-nursing staff in a psychiatric in-patient setting and found that nurses had the highest level of burnout overall. In addition they found that having further educational qualifications had an impact on how staff perceived their environment. Graduates placed less value on order and organisation and rated the level of anger and aggression as higher than those without further education, who were mostly nursing grades. It is likely that for nurses, order and organisation would help them to feel safer given they are required to manage violence and aggression on a regular basis. Squier (1994) found that staff members' attitude towards treatment had an impact on their perception of the ward atmosphere. Those with a greater psychological attitude rated their wards as having less order and organisation and less programme clarity than staff with more 'organic' attitudes. Staff with positive attitudes towards treatment might have higher expectations about order and organisation and programme clarity than those who do not.

In terms of 'role' it has been suggested that forensic psychiatric nursing is a particularly stressful area of nursing (Kilfedder et al., 2001). In a review of forensic nursing literature by Mason (2002) the challenges associated with this type of nursing include being exposed to negative views or contamination of negative feelings, responsibility for the management of violence and potential impact of such, the extent to which staff feel they are having a therapeutic impact, issues related to training, and the impact of the culture of the environment. However, despite these complex issues, some individual research studies have found that staff who work in forensic settings have lower levels of burnout than other settings (Caldwell et al., 2006; Kirby & Pollock, 1995). Conclusions drawn from these studies were that certain helpful staff characteristics may have been present such as optimism and maintaining boundaries effectively (Caldwell et al, 2006) and accepting that stress was an intrinsic part of their job and adapting their coping techniques accordingly (Kirby & Pollock, 1995). In addition Caldwell et al's (1996) study found that the forensic unit was perceived as having higher levels of support, autonomy, order and organisation than the other units. Collectively these studies suggest that job role may have an impact upon how staff members perceive the ward atmosphere but this is mediated by other factors such as personal characteristics, attitudes and level of education.

Although there is a specific 'forensic nursing' role it may be that there is also something unique about the 'forensic environment'. There is evidence to support the idea that the function of the ward might be a salient factor in terms of how staff perceive the ward atmosphere. Moos (1974a) found that wards with more disturbed behaviour had less structure and the rules were less clear (from scores on order and

organisation and programme clarity subscales of the WAS). This was also found to be the case by Kirby (1997), who reported that staff viewed a pre-discharge ward and a long stay rehabilitation ward differently in relation to how active patients were in the programme (involvement) and how explicit the rules of the ward were (programme clarity). In another study specialised units were rated more positively on nearly all dimensions of the WAS opposed to acute units (BootsMiller et al., 1997). Whilst on the surface it appears that the ward function is very relevant it seemed to be more about how these wards operated rather than simply their function. BootsMiller et al (1997) reported that the specialised units had more differentiated staff roles, a clearer specification of treatment outcomes, more distinct client groups and higher staffing levels. Kirby (1997) identified that the pre-discharge ward felt more involved and its treatment directions more identified (involvement and programme clarity subscales).

From the evidence available it seems likely that the characteristics which evolve on a ward do so in response to a range of factors. Certain types of ward are likely to make it more difficult to achieve a therapeutic atmosphere, for example acute wards with high levels of disturbed behaviour and distressed patients. It appears that certain staff characteristics might also be helpful or unhelpful in terms of creating a therapeutic environment. The ward atmosphere can be improved for staff by putting in place ways of achieving order and organisation and programme clarity. Having adequate numbers of staff with clearly defined roles, a predictable routine and strong leadership appear to be important for staff wellbeing. In addition, a sense that patients are making progress towards identified goals appears to be important.

#### **4.1.2 Summary of findings in relation to patients**

Studies of patients' perceptions of the ward environment have primarily considered the relationship between perceptions of ward atmosphere and patient satisfaction, for example Smith et al. (1996); Gjerden and Moen (2001); Middleboe et al. (2001); Rossberg et al., (2006) and Weinstein (1979). Other studies have explored the relationship between ward atmosphere and treatment outcome (Moos et al., 1973; Eklund & Hansson, 1997). Changes in the treatment environment have been reflected in changes in patients' perceptions of ward atmosphere as measures by the WAS. Significant increases were found following positive changes to the treatment regime in a study by Smith et al. (1996) and a decline in perceptions of ward atmosphere and satisfaction were found during a time of crisis in a study by Gjerden and Moen (2001). This indicates that patients are sensitive to the changes around them.

Middleboe et al. (2001) investigated the relationship between patients' perceptions of the 'real' and ideal ward atmosphere and their satisfaction using the WAS and an adapted satisfaction questionnaire. Patient satisfaction was predicted by higher scores on the WAS, in particular support from other patients and staff and a sense of order and organisation. This fits with findings by Eklund and Hansson (1997) in a rehabilitation setting and similarly with ward atmosphere characteristics found to have a positive relationship to staff morale (Dorr et al. 1980; Caldwell et al. 2006).

Rossberg et al. (2006) in a longitudinal satisfaction study found that whilst order and organisation was related to patient satisfaction to some degree, being involved in the programme, the extent to which anger and aggression were tolerated, the degree to which staff exerted control and an emphasis on practical skills and preparation for

release were found to correlate more strongly with satisfaction. This was a well planned study covering a twenty year time period with a large sample size, which indicates that the findings have greater reliability.

It has been found that patient experiences had some impact upon their perceptions of ward atmosphere, for example patients who had been subjected to coercion (according to Danish law on coercion in psychiatric treatment settings) reported significantly less autonomy and practical orientation. They also achieved lower scores on items: satisfaction with staff, satisfaction with medication, and general satisfaction Middleboe et al. (2001). It is likely that wards where a high level of disturbance occurs may be characterised by higher levels of coercion. Therefore it is not surprising that studies have found that patients experience certain environments more negatively. Examples of this include Langdon et al. (2006) who compared low and medium secure learning disabilities services and found that personal problem orientation and practical orientation were perceived as occurring more on the low secure ward and BootsMiller et al. (1997) who found that patients and staff rated specialised wards more favourably than acute wards on all subscales of the WAS. This fits with other findings for staff working in psychiatric in-patient settings (Caldwell et al., 2006; Squier 1994).

Treatment outcome has also been found to relate to ratings of ward atmosphere. Moos et al. (1973) found that patients and staff perceived wards with high dropout rates as giving patients little support and involvement in the programme, being poorly organised with a lack of clear rules. Wards with a high patient discharge rate were perceived as strongly emphasising practical skills and preparation for release but as

relatively unexpressive. Wards that kept patients out of hospital longest were seen to emphasise autonomy and facilitate independence, practical orientation, order and organisation and the open expression of feelings, particularly angry feelings. This indicates that ideally patients should be able to express their feelings within a structured and supportive environment, where the rules are clear and where independence and autonomy are encouraged.

This study by Moos et al. (1973) provided some useful findings regarding treatment outcome. However basic information such as dropout, release and community tenure rates do not provide much detail or depth about what might be considered within the realm of treatment outcome. A more in-depth measure of quality of life, general functioning or symptoms would have been helpful. This type of approach was employed by Eklund and Hansson (1997). They measured treatment outcome using the SCL-90 to measure symptomatology, the COPES (Community Orientated Programs Environment Scale), a measure of quality of life (EOF) and a measure of occupational functioning (AOF). Two groups emerged, one more improved and one less improved. It was found for both groups that the four subscales to be most significantly related to positive outcomes were anger and aggression, practical orientation, personal problem orientation and staff control. Practical orientation fits with the finding from the Moos et al. (1973) study, but the other factors were different. It may be that factors across both studies placed an emphasis on patients' ability to function more independently. Autonomy, practical orientation, personal problem orientation and anger and aggression all fall within the personal growth dimension, and therefore this would imply this type of emphasis. Again, this was a longitudinal study, which is a positive attribute in relation to reliability but the number

of participants was very low, with between 16 and 19 patients completing each measure. Therefore the generalisability of these findings may be limited.

Features which appear to predict patient satisfaction, treatment outcome and staff wellbeing most frequently in research using the WAS are support and order and organisation. Therefore staff and patients both appear to benefit from an environment where there is adequate support for patients and where the ward is structured and organised. However other factors such as personal growth factors for patients can also enhance the working lives of staff and the lived experience of psychiatric settings for in-patients. Unfortunately it is the environments within which it is most difficult to achieve these characteristics that are likely to need them the most.

#### **4.1.3 Comparing staff and patient perceptions of ward atmosphere**

Whilst there are some similarities in what patients and staff value in terms of ward atmosphere there are also differences. It is inevitable that the two groups will have different experiences of the same environment. As highlighted by Goffman (1961) nursing staff might perceive medication, seclusion or privilege systems as part of a therapeutic environment. However patients may perceive these same interventions as humiliating punishment or forced contamination. Despite some studies where staff and patient ratings of ward atmosphere were similar (Morrison et al., 1997; Kirby, 1997), a consistent finding in ward atmosphere studies is that staff and patients rate the treatment environment significantly differently on the WAS, with patients rating it more negatively than staff (Moos, 1974a; Schodt et al; Brunt & Rask, 2005; Rossberg & Friis, 2004; Main & McBride, 1991). In addition there is a clear difference in how staff and patients perceive the degree to which staff exert their control, with patients

perceiving this to be greater than staff (Schodt et al., 2002; Caplan, 1993; Brunt & Rask, 2005; Langdon et al., 2004; Rossberg & Friis, 2004; Main & Mc Bride, 1991; Morrison et al., 1997). Conversely a smaller number of studies found the opposite pattern, for example Kirby (1997), who found that staff were perceived as having less control by patients than by staff. However the sample included in this study was very small in comparison to other studies, with only 16 staff and 13 patients. Similarly Langdon et al., (2006) found that in a learning disabilities setting patients rated the atmosphere more positively than staff. It was suggested that this may have been linked to staff having higher expectations. Given this was a very specific setting the extent to which it is generalisable is unclear.

It has been postulated that a degree of concordance between patients and staff perceptions of ward atmosphere is optimal (Moos, 1974a). Therefore it would seem that this level of difference between the two groups could be problematic. However it makes sense that patients will view the environment differently to staff as they live in the environment as opposed to working in it (Schjodt et al., 2002; Morrison et al., 1997). The notion of congruence was challenged by Main and Mc Bride (1991) who used an Actor-Observer model. This model assumes a tendency for 'self-enhancement' where respondents emphasise positive aspects and minimise negative aspects of activities perceived as within their control. They surmised that where staff accepted responsibility for positive behaviours such as openness, involvement, practicality and support their ratings were higher than were patients. Conversely where something was perceived as negative for example staff control they saw it as less potent than did patients. They considered it more useful to be aware of the likely differences and for the different parties to be able to discuss them openly than to

attempt to achieve concordance between the two groups. It is also evident that by meeting the needs of one group, the impact on the other group is likely to be positive (Lynch et al., 2005; Dorr et al., 1980)

An issue of concern that has been identified through quantitative research is that within mental health settings, patients can easily become marginalised. One study by Brunt and Rask (2007) used an additional free format procedure of asking their sample of 104 staff and 73 patients to write three distinguishing features of the ward atmosphere as well as completing the WAS. They found that there were no distinguishing features of the environment, which could be solely attributed to the patients. Both groups referred to staff contributions, but only one statement out of 139 concerned patients. The patients appeared to be a “peripheral almost invisible figure” on the wards. This highlights an important imbalance between staff and patients in this type of setting and demonstrates how combining standardised and more creative approaches to research can reveal valuable information regarding the ward atmosphere.

#### **4.2 Appraisal of Quantitative Research Designs**

There are some problems associated with using questionnaire based measures with psychiatric in-patients. A commonly reported problem is that there is a potential for a significant number of patient’s views not to be represented. Moos (1974) stated that it was usual to only achieve below a 50 percent response rate for participants in this type of setting. Researchers have found that in some settings patients may be too disturbed to understand the questionnaire (Middleboe et al., 2001). There is also evidence to suggest that even when patients’ views are sought they may be biased if

staff have provided assistance in completing the questionnaire (as in the case of Middleboe et al., 2001). This raises an important limitation of this type of study (Brunt & Rask, 2005). It seems ironic that a primary objective of this type of research should be to enhance the lives of the patients in psychiatric care but their views are not consistently represented because measures are not always suitable for the client group.

There have been some questions over the psychometric properties of the WAS. Alden (1978) suggested that the WAS is largely a measure of attitude rather than a measure of ward atmosphere, primarily tapping into how positively a subject felt about the ward. It would appear that it is difficult to achieve an objective measure of ward atmosphere by asking participants to rate the environment in this way. In addition Rossberg and Friis (2003) suggested that because several of the scales are strongly inter-correlated it was questionable how many dimensions the WAS actually measured. They found that the psychometric properties of the WAS were improved if 16 items were removed from the scale.

There are other content-related issues to consider in relation to the WAS such as the length of the questionnaire (Schalast et al., 2008) and the wording of some questions being somewhat dated (Rossberg & Friis, 2003). Asking patients who may be very disturbed or lacking in motivation to complete an arduous 100 item questionnaire is a major challenge within settings such as acute units and similar environments. It would appear that this may be easier if the measure was shorter. A shorter (17 item) questionnaire has recently been developed for forensic settings Schalast et al. (2008). The 'EssenCES' is in the process of being validated in forensic settings. This

measure includes a focus upon ‘perceived safety’, which does not appear in the WAS. Using a revised version of the WAS as suggested by Rossberg and Friis (2003) or the EssenCES measures may be of benefit in future. The EssenCES (or adapted version of it) may be particularly relevant in the current context of mental health services because of its emphasis on perceived safety and ‘therapeutic hold’. Given recent criticisms of mental health services as neither safe nor therapeutic (DoH, 2002) an instrument such as this could have significant merit. Using new or adapted measures would make comparisons with previous research difficult but would potentially bring quantitative research into ward atmosphere more up to date and improve access for marginalised patients.

It has to be questioned whether all aspects of ward atmosphere can be elicited using a fixed questionnaire. Whilst a small number of studies supplemented the WAS with other outcome measures, these were few in number. Those which did accessed some interesting and potentially important findings (e.g. Brunt & Rask, 2007) Whilst it is useful to have an understanding of what general factors are perceived as positive or negative within specific environments, fixed measures seem to provide a rather bland picture of the ward atmosphere. For example, taking into account the relationship dimension of the WAS, relationships are reduced to a set of questions, to which a ‘true’ or ‘false’ answer is required. By reducing a complex issue such as relationships to a small number of fixed questions, it seems that something is lost in terms of complexity and significance. This makes it difficult to ascertain what specific measures or actions might be taken to improve areas which are deemed inadequate. Quantitative research has provided some valuable findings about the aspects of ward atmosphere that are conducive to a positive experience for staff and patients but there

is a limit to how much depth and detail can be elicited from this type of approach.

One of the benefits of quantitative research is intended that results may be generalised beyond the immediate setting. However due to different treatment settings, vastly different sample sizes and incompatible methodological approaches across the studies generalisability is limited within this area of research.

#### **4.3 Overview of Findings from Studies Using Qualitative Research Designs**

One way of addressing some of the problems associated with quantitative research designs in the area of ward atmosphere such as (i) power imbalances between staff and patients; (ii) reliance on inflexible and potentially restrictive questionnaires that do not take into account the different positions of staff and patients, and (iii) the potential lack of depth and detail achievable by questionnaire measures alone is to use qualitative research designs. There have been a number of qualitative studies, which have contributed to the understanding of ward atmosphere by using observation or interview designs.

Hummelvoll and Severinsson (2001) used observations and interviews to explore mental health professionals reflections on the care provided on a psychiatric ward. Themes were categorised into ‘thriving’ or ‘strain’. Within the theme of thriving were included having good team relationships, feeling valued and feeling the work was significant. Under the theme of strain were feeling inadequate, diffuse directions in the work situation such as long lasting seclusion without clarified guidelines and finding it hard to experience patients’ suffering and detrimental physical milieu. This seems to reinforce the notion identified in quantitative research that it is beneficial to staff members’ sense of wellbeing to see patients making progress. It also suggests that when staff feel inadequate and pulled in different directions they will be under

strain. In psychiatric settings it must be acknowledged that there are numerous and sometimes conflicting roles for staff (Kurtz, 2002; Menzies-Lyth, 1979).

Hummelvoll and Severinsson's study provides further evidence that certain environments such as those with high levels of disturbance and use of seclusion are likely to raise particular challenges for staff.

From the quantitative research it emerged that ward function was likely to have an impact on the ward atmosphere. An observation study by Katz and Kirkland (1990) of six wards (four acute and two long-term) conducted a detailed analysis of this by examining why wards with the same function and very similar patient characteristics and diagnoses might have very different atmospheres. They used interviews, observations and incident recordings over a 38 month period. Violence was more frequent and extreme in wards where staff functions were unclear and in which staff-patient encounters were unpredictable. Where there was strong leadership, clearly structured staff roles and standardised and predictable events violence was less frequent and extreme and staff morale was high. This suggests that within two similar wards, different atmospheres can be achieved regardless of the function of the ward. This study highlighted that the social and organisational climate on the ward was largely a function of the psychiatrist in charge. In the current context, the dominance of psychiatry may be less evident than when this piece of research was carried out. It raises the question of how is leadership provided and by whom. The issue of containment is likely to be an important one for both staff and patients.

An interview study with patients employing a descriptive existential phenomenological approach by Thomas et al. (2002) involved interviews with eight in-patients on an acute psychiatric unit. This research is one of the only studies

available where patients' views were sought beyond the use of a fixed measure. Themes identified within the hospital setting as a "refuge from self-destructiveness" included: like me / not like me concerning identity, possibilities / no possibilities concerning the patients' futures, and connection / disconnection concerning communication with others. Patients reported wanting a deeper connection with staff and perceived relationships with other patients as the most beneficial part of being in hospital. Therefore in practical terms, having consistent staff on a ward might have a positive impact on patients' experiences of being in hospital. Issues such as staff shortages and health service cutbacks are likely to have a significant impact on staffing and the degree to which patients feel able to make meaningful relationships with staff. Ward management practices such as the proportion of agency and permanent staff or whether wards have dedicated staff may be very important.

Largely neglected in quantitative studies of ward atmosphere is a focus on process issues within psychiatric ward settings. Donati (1989), replicated by Goodwin and Gore (2000), carried out a study observing staff and patients in a complex mental health setting. They both revealed dynamic processes embedded in the culture of the ward, which in the context of ward atmosphere provided some valuable insights, which could not be made using a standardised measurement instrument. Amongst other findings, Donati (1989) found that nurses spoke about patients as though they were not there, whilst complaining of a lack of meaningful contact with patients (as also found by Thomas et al., 2002 from patients' perspectives). The observer herself found that she was related to in a similar depersonalised way to how staff reacted to patients. Outwards there was boredom, monotony and an absence of interactions, emotions and events but underneath there were pervasive anxieties, which were dealt

with defensiveness by staff. These anxieties were identified as coming from different sources: a massive impotence in the face both of chronicity of patients' problems; identification with the patients as social rejects; and a lurking fear of madness, stagnation and emptiness. There appeared to be an attempt to keep everything lifeless and predictable.

The notion of lifelessness and limited relating to residents also emerged from the study by Goodwin and Gore (2000). It was observed that reduced contact time, social distancing and emotional detachment were strategies used by psychiatric ward staff. In addition there were aspects of uncertainty regarding staff roles and staff sometimes appeared to see the ward as their home and somewhere for them to enjoy themselves as if there was a role reversal between staff and patients. It was concluded that staff employed defences against association with patients' problems such as disability and mental disturbance. This study suggested that the things that might have improved morale on the ward would not be encouraged by the hospital culture, for example increased intimacy between staff and patients. In addition, it put forward the idea that the denial of negative feelings by staff stopped them from being able to use each other for support. Aspects of organisational culture and the wider cultural context are of crucial importance when considering how staff and patients perceive the treatment environment.

In addition to providing an opportunity for in-depth consideration of ward culture and interactions observations allow researchers to use their own experiences to help them to understand what is happening around them. Edwards (2000) demonstrated this in an observational study in a long stay psychiatric ward. The researcher discovered that

the ward environment had affected her and her sense of time and place had become muddled. She reflected that this was likely to be a similar experience to that of the patients she was observing. She described paradoxically having found the experience both overwhelming and empty. The researcher commented on gaining particular insights through active participation on the ward. It was not the type of information or experience which could have been elicited from the use of a questionnaire.

#### **4.4 Appraisal of Qualitative Research Designs**

Finding from interview based studies seem to fit with ward atmosphere findings to some degree, for example the emphasis on positive relationships between patients and staff but they also draw out other interesting areas for exploration such as patients' identity, relationships between staff and staff members' feelings about experiencing patients suffering. These issues are not really addressed by scales such as the WAS. Questionnaire studies can respond to individual settings and participants and may allow for consideration of unusual or unexpected topics to be followed up.

Observation studies are particularly useful and different to the other approaches as they do not rely on self-report, making it less likely respondents wanting to present either a negative or positive picture will confound the results. In addition it is possible to use observations in situations where participants are too distressed or disturbed to participate in completing questionnaires or interviews. One of the significant benefits of both observation and questionnaire based studies is that they make it possible for the researcher to make interpretations about what is being observed. For example, as demonstrated by Donati (1980) and Goodwin and Gore (2000) unconscious processes such as psychological and social defences can be considered. This seems to be

particularly important in the current context where staff in numerous different settings face a range of challenges such as working with traumatic material, being exposed to violence and managing complex organisational and ward dynamics.

Collectively, qualitative methods are useful in terms of achieving greater depth and detail of human experiences and reduce the difficulties associated with self report and lack of inclusion. However there are other limitations such as difficulty quantifying what is observed, and making generalisations beyond the context where the study is taking place. Weinstein (1979) criticised qualitative research approaches for not being systematic and not focusing upon patients themselves, rather the effect of hospitalisation upon them. This could certainly be true, particularly of observation studies where the views of patients may not be sought. However a lack of focus on individuals themselves could be levelled at any type of research with marginalised groups and highlights the importance of taking sufficient steps to avoid such. Current qualitative approaches such as Interpretative Phenomenological Analysis (Smith & Osborn, 2003) are concerned with individual experiences, and therefore are likely to be very sensitive to what is important to participants. This type of approach may be too intense and time consuming for very disturbed patients, but would be a welcome addition to the literature.

## **5. Conclusions and Implications for Future Research**

Currently in the UK patients stay in in-patient services for less time, are more likely to be detained and staff and patients are more likely to be at risk of violence than previously (Norton, 2004). Services are constantly being challenged to provide high quality care with ever-reducing financial resources, whilst facing scrutiny and

criticism when things go wrong. It seems that there has never been a more important time to consider ways of providing good quality care to patients and staff working with them.

Currently there are significant shortcomings in the provision of in-patient care, and there is a particular difficulty in involving service users and their families in their care. This is also reflected in research methods in terms of the most marginalised patients being the least likely to be involved in research. Research evidence suggests that staff and patients have the most negative experiences of acute wards, which due to high levels of disturbance are likely to have the poorest organisation and support and emphasis on personal growth for patients. Research indicates that staff and patients benefit from being able to see that patients are working towards greater independence and meeting therapeutic goals. An acute ward is likely to be one of the most difficult for staff and patients to hold in mind the idea that recovery and greater independence is achievable.

Research needs to respond to the social and political context. It would appear that current priorities are to include service users and carers more in patient care, address the perception that in-patient settings are not always safe or therapeutic and increase the focus on individual care and achieve these priorities within a realistic financial framework. Previous research has not always made it possible for marginalised patients to be involved and has not necessarily provided ways of translating findings into practical processes to improve ward atmosphere. Ways in which research might reflect the current socio-political priorities and offer practical utility in current mental health settings are as follows:

- To utilise observation studies on acute wards to understand more about interactions between staff and patients and explore ward dynamics. This approach would increase opportunities to involve patients who might otherwise be marginalised and provide insights into how to improve the therapeutic atmosphere on acute wards for both staff and patients.
- To identify ways in which quantitative measures might be made more accessible and up to date for use in modern settings by (i) adapting current standardised measures such as the WAS to be shorter and more relevant to the current context or (ii) using other more up to date measures such as the EssenCES questionnaire (Schalast et al., 2008), which incorporates a focus upon perceptions of safety. This is particularly relevant in the current context and an adapted version of this or a similar measure would be helpful for non-forensic settings. In addition, supplementing questionnaire-based measures with more creative measures can provide a different dimension to quantitative research.
- To use the outcomes from research to work with staff and patients together in order to improve the therapeutic environment. Rather than to attempt to achieve agreement between the two groups, it may be more beneficial to acknowledge that different roles are likely to influence perceptions but there are still aspects of ward atmosphere such as support, order and organisation and factors relating to patient personal growth which might be the most likely to make the biggest difference to both groups.

- To increase opportunities for patients to have an input into research and evaluation of ward atmosphere. Significantly disturbed patients should be included in service evaluations at appropriate times, when considered to have the capacity to consent to being involved. This might require staff to be proactive and flexible in terms of ascertaining when this should occur.
- To use research outcomes to determine ways of making practical changes to meet the needs identified in current mental health care.
- To incorporate more in-depth qualitative interview based methods in research with patients and staff such as Interpretative Phenomenological Analysis and Grounded Theory to explore experiences of ward settings.

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## **PART TWO: RESEARCH REPORT.**

The experiences of staff working in secure forensic child and adolescent mental health  
services: Exploratory interviews.

Word count: 13424

## Research Report Abstract

**Purpose:** To explore the experiences of staff working in forensic child and adolescent mental health services using a qualitative approach.

**Method:** Interviews were undertaken with nine members of staff within secure forensic units for young people. The interview transcripts were analysed using an Interpretative Phenomenological Analysis approach.

**Results:** Participants described having a range of experiences within their work, both positive and negative. Themes identified through the process of analysis were: powerful internal experiences, impact of the environment, negotiating complex staff relationships and managing complex client dynamics.

**Conclusions:** Staff within forensic child and adolescent mental health services have a range of challenges within their work and they require appropriate support to manage the demands of such.

Key words: forensic, child and adolescent mental health, staff,

Target Journal: Criminal Behaviour and Mental Health

## **1. Introduction**

### **1.1 Adolescent Mental Health, Offending and Secure Services**

In recent years, the profile of children and adolescents who offend has increased, in response to a rising numbers of crimes committed by young people being recorded. Official statistics report that 26 percent of known offenders are under the age of 18 (Audit Commission, 1996) and between 2002 and 2003 there were 7,000 custodial sentences awarded to children between the ages of 10 and 17 (National Audit figures, 2004). In addition there is evidence that nine out of ten juveniles re-offend following their release from secure settings (National Association for the Care and Resettlement of Offenders, 2002).

Adolescent offenders who are placed in either young offender's institutions or secure health facilities have extensive needs (Wheatley et al., 2004). However, historically these have not been well recognised, widely understood, nor adequately met (Kurtz et al., 1998). The range of problems experienced by these young people include substance abuse problems (Erwin et al., 2000); conduct disorder (Tarolla et al., 2002); mental illness such as psychosis (Lader et al., 2000); psychopathy (Farrington, 2005); emerging personality disorder (Lader et al., 2000); and post-traumatic stress disorder (Wheatley et al., 2004). A needs assessment by Kurtz (2006) identified that children who met the referral criteria for secure forensic services had treatment needs in relation to mental health, education, relationships, violence and risky behaviour.

## **1.2 Current Provision of Care**

In response to increased awareness of the need for adequate mental health provision for young offenders (Kurtz et al., 1998) there has been a governmental commitment to improving the facilities for young people with complex difficulties who offend. This has resulted in the commission of six national forensic child and adolescent mental health services (FCAMHS). This development was commissioned by the National Specialised Commissioning Advisory Group (NSCAG), which advises ministers on the identification and funding of specialised services. National initiatives such as the Green Paper 'Every Child Matters' (Department of Health, 2003), and 'Troubled Inside: Responding to the Mental Health Needs of Young People in Prison' (Prison Reform Trust, 2002) have underpinned these developments. These new services are multidisciplinary in their approach and offer a tailored educational and activities programme. This is regarded as a key element for improving outcomes for young people (Kurtz, 2006).

## **1.3 Specific Issues of Working with Young People with Complex Needs**

Given the complex nature of these young clients' difficulties, and the context within which the work occurs, this type of work is likely to impact significantly on staff. However the specific issues relating to working with this particular client group have not been widely researched. Rose (2002) stated that the relationships formed between staff and patients within secure settings are beneficial on a number of levels, for example in terms of modelling, increasing motivation and developing self esteem. However the degree to which staff can provide what is needed for the young people depends on a range of factors.

From the literature regarding working with disturbed children and adolescents, there appear to be challenges for staff from both from an individual and systemic perspective. Hunter (2001) stated “it can be a painful and hazardous process” working therapeutically with children who have experienced trauma, due to the transference that can occur within the therapeutic relationship. Menzies-Lyth (1979) stated that within children’s institutions, staff members have a crucial responsibility to control their own boundaries so as to manage the effects of both projection and introjection from the young people. There is a danger for care-givers to act on projections from the young people in their care rather than treating them as a communication. Staff within this type of setting may be required to attend to and process complex transference and countertransference issues in order to understand their experiences and retain their personal boundaries (see also Winnicott, 1949).

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#### **1.4 General Issues of Working in Forensic and Mental Health Settings**

Because there is very little research into secure settings for young people most assumptions about what it might be like for staff to work in FCAMHS has been drawn from literature relating to adult forensic and mental health work. It seems reasonable to assume that working with young clients with similar difficulties could present as many challenges if not more given their young age and potential vulnerability. Previous research in forensic mental health settings has identified a range of challenges for staff.

The conflict between therapeutic and custodial roles has been identified in existing literature as a challenge to staff within secure settings (e.g. Lynch, Ryan & Plant, 2005; Kurtz, 2002). As stated by Hinshelwood (1993) there may be something of a

clash in these cultures. One study by Epps (1994) highlighted this as a specific issue in relation to working in a secure unit with young sex offenders. The potential for exposure to aggression and violence is also a specific issue within this type of work environment. Assault on staff was found to be prevalent in a study of staff and patients in a psychiatric hospital for young people (Lynch et al., 2005).

Vicarious trauma and burnout have been identified as potential risks for staff working with people with complex difficulties. Vicarious trauma can result from repeated exposure to numerous clients who have been traumatised (McCann & Pearlman, 1990). Burnout has been described as a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who work with other people in some capacity (Maslach et al., 1996). Working with traumatised children has been suggested as a risk factor for these syndromes by Figley (1995) and Azar (2000) respectively. However there is limited evidence to support this as a specific risk factor at the current time.

Psychodynamic observations within psychiatric and general hospital settings have revealed that there are complex dynamics occurring not only at an individual level between staff and patients, but also at an organisational level. Hinshelwood and Skogstad (2000) described how the specific quality of relationships, and the forms of practice that the cultural attitudes within an organisation promote, give rise to the characteristic atmosphere that pervades an organisation. This fits with the notion of a social defence system as defined by Menzies-Lyth, (1959) within a general hospital setting and Donati (1989) within a psychiatric setting. This system serves to protect its

members from expressing and acknowledging anxieties generated by unconscious impulses, which can have a negative impact upon both staff and patients.

### **1.5 Summary**

There are numerous potential challenges faced by staff working with young people with complex needs in secure settings. Currently there is little research in this area. Issues such as the complexity of clients' difficulties, exposure to traumatic material, risk of assault, complex transferences and counter-transferences and individual and organisational defensive processes are amongst the potential factors which could impact upon the experiences of these staff.

### **1.6 The Current Research Study**

Given the increase in service provision, it was considered useful to carry out an exploratory study of this nature in order to explore the experiences of staff working in FCAMHS. The aims of the research were to identify salient aspects of staff experiences, which could form the basis for a larger scale research study in future. Ideally this data could then be used to help to improve and develop current and future service provision.

The research questions were:

- What are staff members' experiences of their work?
- How do they understand their task?

## **2.0 Method**

This section describes the study design and the rationale for selecting Interpretative Phenomenological Analysis (IPA) as the method of analysis. The chapter then describes the participants who took part in the study, the development of the interview schedule, the process of transcribing and analysing the interview data and the quality measures adopted in the study.

### **2.1 Overall Design of the Study**

It was considered appropriate to use a qualitative approach for this particular study. Qualitative research can be described as an ‘interpretative’, ‘contextual’ and ‘naturalistic’ mode of enquiry (Henwood & Pidgeon, 1996). It is an ‘exploratory’ method, used to explore a topic when the variables and theory base are unknown (Cresswell, 1994). As stated by Ashworth (2004) qualitative research, regardless of which specific approach focuses on experience. The study aimed to capture the quality of the experiences of the participants. A semi-structured interview was selected to allow for flexibility to follow up relevant areas of interest that emerged during the interview (Smith, 1995).

### **2. 2 Ethical Approval**

Ethical approval was sought from a Multi site Research Ethics Committee (MREC) to allow for more than one FCAMHS unit to be involved in the study. Ethical approval was granted in September 2007 (see Appendix A). Prior to data collection, a request was made to the ethics committee to change the method of analysis from Grounded Theory to Interpretative Phenomenological Analysis. This was approved on 1<sup>st</sup>

November 2007 (see Appendix B). The reasons behind this amendment to the design of the study are described in more detail in section 2.3.3.

## **2.3 Epistemology and Choice of Method**

### **2.3.1 Researcher's position**

The epistemological stance adopted by the researcher in the current study was most closely aligned to a critical realist position. This position combines aspects of constructionist and realist positions (Sims-Schouten et al., 2007).

The researcher believed that what was said by participants during the interview had some significance and reality for them beyond the bounds of the interview situation, that it was part of their ongoing self-story and represented a manifestation of their psychological world, whilst being connected to a world outside (Smith, 1995).

The researcher had previously worked for several years as a member of a multidisciplinary team within prison based therapeutic communities. She had found this to be an intense and challenging environment, which was characterised by powerful dynamics on a number of levels, between staff and residents, between professional groups and between the staff team and management. The researcher experienced and observed a conflict between therapeutic and custodial responsibilities and it seemed particularly difficult for different professional groups to share a coherent model of their work. The researcher became interested in exploring how members of staff working in child and adolescent mental health units experienced their work. She believed that these staff would potentially face additional challenges in relation to the young age and mental health needs of their clients. She was invited

to plan and carry out the first in a series of planned studies to coincide with the recent expansion of national services for adolescents with forensic and mental health needs.

### **2.3.2 Interpretative phenomenological analysis**

Interpretative Phenomenological Analysis (IPA) has theoretical roots within phenomenology and symbolic interactionism. Smith (1996) described phenomenology as broadly concerned with an individual's personal perception or account of an object or event as opposed to an attempt to provide an objective statement about the object or event itself. Symbolic interactionism argues that the meanings ascribed to events or objects are only obtained through a process of interpretation. These meanings occur (and are made sense of) in, and as a result of, social interactions. A central premise of the IPA method is allowing participants to tell their own story, in their own words, about the topic under investigation (Smith et al., 1997). IPA also emphasizes that the research exercise is a dynamic process, where the researcher takes an active role. Therefore there is a two-stage interpretation process occurring, where the participant is trying to make sense of their world, whilst the researcher is trying to make sense of the participants trying to make sense of their world (Smith, 1996).

### **2.3.3 Rationale for selecting IPA methodology for the study**

The researcher initially considered that Grounded Theory (GT) may be the most appropriate approach for the study. However upon more detailed exploration of both GT and IPA approaches it was considered that IPA would be a more appropriate method. The researcher considered that whilst both approaches offered flexibility and opportunity for interpretation, the specific premises of IPA, which lent themselves to this particular study were (i) the underlying assumption within IPA that the sample is

homogenous (in this case all participants working in the same work environment), (ii) whilst being grounded in the text, IPA seems to allow particular scope for moving beyond the text to a more interpretative and psychological level, (iii) a strong focus upon subjective experience, (iv) the absence of a pre-determined hypothesis and (v) a concern with complexity, process or novelty (Smith & Osborn, 2003). As suggested by Kurtz (2002) defensive aspects of forensic organisations are likely to provide particular challenges to researchers, and attempts to acknowledge the powerful emotions aroused in staff working in these organisations can meet with a negative response. For this reason it was considered particularly important to utilise an interpretative research method. Due to the lack of research in this area, it was considered beneficial to use a method which was concerned with novelty, complexity and process. In addition the Researcher did not aim to build inductive theory from the research data as would be the case with GT (Charmaz, 2006).

## **2.4 Participants**

### **2.4.1 The sample**

Nine participants were involved from two FCAMHS units in the UK (unit Y and unit Z). All participants were working in FCAMHS at the time and were from a range of professional groups: nursing (various grades, qualified and unqualified), psychiatry, psychology and education. Participants were asked for basic demographic information, shown in Table 1. The demographic information has been presented in this format rather than individually to protect the participants' anonymity.

**Table 3. Characteristics of staff participants from unit Y and unit Z**

<b>Gender</b>		<b>Ethnicity</b>	
Female	6	Black African	1
Male	3	White British	5
<b>Age</b>		White Other	2
26-30	2	Indian	1
31-40	2		
41-50	2		
51-60	3		
<b>Time since qualification</b>		<b>Time in current job (nearest 6 months)</b>	
Average	15 years, 6 months	Average	3 years
Range	7 months – 36 years	Range	7 months - 7 years, 6 months

#### **2.4.2 Recruitment of participants**

Links were made with the two FCAMHS units via an agreed liaison person.

Participants registered their interest either by replying to an information sheet sent by the researcher (contained in Appendix C) or via the liaison person. The sample from the first unit was selected on the basis of when the majority of people were available for interview. The initial focus was upon nursing staff as they were the largest professional group. A range of nursing staff grades was intentionally selected to include a range of levels of experience and responsibility. Potential participants at the second unit were approached by the liaison person following discussion with the researcher on the basis that they might have something interesting to say, which would enhance the research.

#### **2.5 Development of the Interview Schedule**

The development of the interview schedule was a significant part of the study. As stated by Burman (1994) work done prior to conducting interviews is “...usually amply repaid in terms of its success and ease of analysis.” Two pilot interviews were carried out and the final interview schedule used was the fourth revision (see

Appendix D for an example). The pilot interviews seemed to lack depth in terms of the participants' experiences and seemed to tap into general concepts and intellectualisations more than emotional experiences. An example of this was when the researcher asked the participant to talk about a piece of work they had found difficult. The researcher was intending to tap into something that felt difficult in an emotional sense, but the participant responded with a description of a difficult practical situation they had to manage. This occurred frequently within the two pilot interviews.

Holloway and Jefferson (2000) stated that there are unconscious dynamics that occur in the research interview, for example defences against anxiety on either the part of the researcher, participant or both. Participants may be invested in particular positions in discourses to protect vulnerable aspects of self or be motivated (maybe unconsciously) to disguise the meaning of some of their feelings and actions. In order to address this, the researcher utilised four principles adapted by Holloway and Jefferson (2000) as far as possible in the interview schedule. This entailed (i) using open ended questions; (ii) eliciting stories which anchored peoples' accounts to actual events; for example asking "can you tell me about a time when X happened?"; (iii) avoiding 'why' questions, and (iv) following up participants' themes in narrated order and using their own words and phrases. In addition, the researcher used a technique taken from the Adult Attachment Interview (AAI George, Kaplan & Main, 1985). The original technique described by Hesse (1996) involved seeking general descriptions regarding the respondent's relationship with their parents in childhood, followed by a request for a number of adjectives to represent the relationship with each parent, followed by a request for specific episodic memories that would illustrate

or support why each descriptor was chosen. Hesse (1996) suggested that this process of having to reflect on memories whilst simultaneously maintaining coherent discourse with the interviewer can surprise the subconscious, leaving people unable to provide clear answers and having frequent opportunities to contradict themselves. The researcher adapted this technique to ask participants about their work. The level of coherence in the individual's account can provide an insight into their attachment style within the AAI. The researcher expected that this technique would provide a way of reflecting upon the coherence of the participants' account and to examine defensive strategies, which may be used within the research interview.

### **2.5.1 The interview process**

Participants were interviewed at their place of work in a suitable room, at an agreed convenient time. Each interview was digitally recorded for transcription after basic demographic information had been collected, key information from the participant information sheet briefly discussed and the consent form signed (see Appendix E). The interviews lasted between 35 and 80 minutes. Five of the nine interviews did not begin on time due to participants having clashing commitments such as meetings or unexpected events or incidents, which they were required to be involved with. Two interviews were interrupted whilst they were in progress resulting in participants having to leave the room, and three participants stated that they had less time than originally agreed for their interview. Following each interview, the participant was asked how they found the interview in order to ascertain whether the participant was distressed and required any support. They were also asked if they would like to receive feedback after completion of the research and reminded of how to contact the

researcher should they wish to discuss anything. The researcher recorded her reflections of the interview process in a log immediately after each interview.

### **2.5.2 Transcription and analysis of interview data**

The interviews were transcribed, including each word spoken by the researcher and the participant, pauses, laughs and hesitations. The analysis began following the first set of interviews. The researcher approached the analysis of the interview data as suggested by Smith and Osborn (2003), with the aim of understanding the content and complexity of the psychological world of each participant rather than measuring the frequency of a particular element of their story. This process began with the analysis of what the researcher considered to be the richest of the first six interviews. All interviews were analysed by recording significant information in the left hand margin to begin with. This involved the researcher attending to participants' use of language, making connections between different parts of the transcript, observing contradictory comments, or associations within their account. The overall aim was for the researcher to capture the essence of what was coming across from the participant, whilst asking questions about what might be absent from the account. Following this process, the researcher documented emergent themes in the right hand margin. This involved transforming the initial notes into phrases, which captured the quality of what was found in the text, whilst moving the response to a higher level of abstraction. The researcher attempted to find ways of describing the themes in a way which incorporated psychological and theoretical ideas, whilst being grounded in what the participant said. These themes were then clustered into super-ordinate themes by considering which themes seemed to be related to each other in some way.

Further analysis continued during the writing up stage and the themes continued to evolve as the researcher developed her thinking about the material.

### **2.5.3 Use of psychological theory in the analysis**

The use of theoretical constructs in analysis of data within an IPA study has been criticised for potentially violating IPA's phenomenological commitment by overwriting the subjectivity of the individual participant's account with researchers' theories (Storey, 2007). However it was considered appropriate in this case to utilise a psychoanalytic framework to consider some of the processes which occurred during the research, for example when defensive strategies were observed by the researcher. Whilst this is unusual in IPA work, other researchers have found this to be a useful approach in some circumstances. In order to reduce the risk of violating participants' subjectivity the consideration of psychoanalytic concepts was employed as a way of informing rather than driving it (Coyle & Rafalin, cited in Lyons & Coyle, 2007).

### **2.5.4 Quality measures.**

It is important that research can be assessed in terms of quality (Elliot et al., 1999; Yardley, 2000). The researcher attempted to utilise the characteristics of good qualitative research suggested by Yardley (2000) Examples of how this was achieved for each area are provided below:

- *sensitivity to context:* The researcher was aware of previous research and literature in the area and related areas and continued to update her knowledge during the research process.
- *commitment and rigour:* The researcher was a member of a qualitative research group and received regular research supervision. To enhance inter-

rater reliability a full interview was coded by an independent person, and an excerpt of another interview was coded by the members of the qualitative group.

- *transparency and coherence*: The sample was selected in terms of its ability to supply all the information needed for a comprehensive analysis. In addition the researcher was transparent about the procedures involved in the research and her own position. The researcher kept notes of her experience of the process of analysis in order to keep in mind any interesting or puzzling aspects of the process and what had shaped the development of the themes and sub-themes.
- *impact and importance*. The research was considered to be of great practical utility and a valuable contribution to a developing area of research.

### **3. Results and Analysis**

Section 3.1 contains the results from the first level of analysis, specifically the themes that emerged from analysis of the interview transcripts. A table of these themes is shown in Figure 1. Section 3.2 contains the second level of analysis, which relates to the dynamic and experiential aspects of the research process. Here is provided a description of how the researcher made sense of aspects of the interview process, including her own reactions and ways of understanding these in relation to the participants' experience of their work. This section includes key quotes to illustrate the categories<sup>1</sup>. These quotes are referenced in the text in brackets, in the form of participant number, followed by the line number (e.g. Z1,34)

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<sup>1</sup> Some demographic details have been fictionalised in order to protect the anonymity of the participants, for example gender or professional group

### **3.1 First Level of Analysis**

#### **3.1.1 Overview of themes**

The units were described as intense environments within which to work. Four super-ordinate themes made up of a total of 14 sub-ordinate themes:

##### **(i) Powerful internal experiences**

Participants described a range of powerful internal experiences in relation to their work, which included the loss of their professional identity following incidents experienced as undermining, a rollercoaster of emotions as a feature of the work and the use of survival mechanisms to manage the difficult feelings aroused by their work.

##### **(ii) Impact of the environment**

Participants described the physical environment as having an impact upon them. The units were perceived as separate entities and different to the world outside, as physically oppressive and constantly changing.

##### **(iii) Negotiating complex staff dynamics**

Participants' relationships with colleagues were complex and characterised by contradictory experiences of teamwork, negative experiences of authority, power and powerlessness, a fear of openness and a preoccupation with being judged.

##### **(iv) Managing complex client dynamics**

Participants described intense experiences in relation to the young people in the unit. Issues around engagement and disengagement were evident for staff in their relationships with the young people, a sense that tasks were frequently in conflict, a

reliance on structure and security and a real challenge focusing upon the individual young people within a system.

**Figure 1: The final representation of clustered themes**

<p><b>1. Powerful internal experiences</b></p> <p>Loss of professional self</p> <p>Roller coaster of emotions</p> <p>Survival mechanisms</p>
<p><b>2. Impact of the environment</b></p> <p>Physically oppressive</p> <p>A separate entity</p> <p>Continually changing</p>
<p><b>3. Negotiating complex staff relationships</b></p> <p>Contradictory experiences of teamwork</p> <p>Negative experiences of authority</p> <p>Power and powerlessness</p> <p>Fear of openness</p> <p>Preoccupation with being judged</p>
<p><b>4. Managing complex client dynamics</b></p> <p>Engagement and disengagement</p> <p>Tasks in conflict</p> <p>Structure and security</p> <p>Individual versus the system</p>

### **3.1.2 Theme 1. Powerful internal experiences**

Participants described a range of powerful internal experiences in the course of their work and in relation to a variety of situations. These descriptions were provided both spontaneously and in response to specific questions in the interview such as “*have you had any strong feelings at work recently?*”

#### **Loss of professional self**

For some participants, the feeling of having lost something came across very powerfully. This theme was almost exclusive to unit Z, which had been open for longer than unit Y. The perception of loss was generally described in relation to a specific event.

“ I felt very confused erm after I was seriously assaulted ... I was very confused about whether I could risk assess erm how I couldn’t read situations far in advance because I’m normally very good at that.” (Z3, 418-420)

This sense of loss was echoed by another staff member, he describes how he felt when a decision he had made was overturned by other staff:

“So that makes me think and question all of that work that I’ve done now... I’m starting to question my own abilities so hence the lack of confidence.”  
(Z6, 216- 220)

He went on to say

“ ... it’s like a bereavement I’m going through the loss of something and that loss is my motivation and my enthusiasm for what I did.” (Z6, 545-547)

For these participants the sense that something had been lost in relation to a specific event was explicit and it seemed that during the interview they were attempting to make some sense of what this meant. Whilst not stated explicitly, the researcher got the impression that this loss had impacted upon the participants’ professional identity in a general sense and this was highlighted by their struggle to come to terms with the new situation they found themselves in.

### **Roller coaster of emotions**

Participants spoke about a range of extreme emotions in relation to their work. The range of thoughts and feelings described by one participant in relation to work was as follows:

“exhausting... emotionally and physically tiring... hurt... excited... delighted... hopeless... heaven... grind... unhappy.” (Z1)

Another participant, who when asked about her feelings about her work replied:

“...it’s a bit like a roller coaster...” (Y1, 485-486)

The idea of a roller coaster seemed to encapsulate the extremes described within participants’ accounts of their work. There was a sense that this type of work aroused both highly positive and negative emotional experiences for participants.

### **Survival mechanisms**

Participants made a number of references to protecting themselves from the potential psychological impact of their work. One participant provided an example of managing anxieties about the potential risks that the young outpatients might pose:

“So once they leave our outpatients department I really have no way of knowing exactly what they’re getting up to ... they could be running amok down the centre of [Birmingham] with a gun and because I saw them the day before you know I’m gonna have a lot of paperwork, a lot of justifying what I’ve done...if you kept that in mind...you just wouldn’t be able to function because you’d start deteriorating on your ability to see patients, you’d be too scared...” (Y2, 147-154)

Other participants made reference to ways in which they protected themselves from the potential impact of the work. For example one participant described how they kept an emotional distance from the clients:

“I know when I get home I can’t feel sorry for them because then I can’t do my job I have to close the book...otherwise er I will end up myself in a mental health unit.” (Z4, 109-112)

Other members of staff spoke about how difficult experiences at work had led to a re-evaluation of their view of work. There was a clear sense that they were not willing to allow themselves to be vulnerable to such experiences again. The example below relates to one participant’s experience of being assaulted:

“...I’m very very wary if I take any young person out ever and I don’t do many leaves...” (Z3, 330-338).

Participants did not necessarily say they recognised their behaviours as survival mechanisms, but the researcher felt that avoiding thinking about certain issues and avoiding certain tasks made it possible for participants to continue to do their job. The first example brings home the almost unbearable thought of what a young patient might be capable of and how dwelling on this would be detrimental to doing the work. In each case there was a sense of some distressing consequence of not using survival mechanisms, for example going mad, being responsible for a patient who causes harm or being harmed oneself.

### **3.1.3 Impact of the environment**

Participants made references to the physical environment of the units frequently, despite this not being included in the interview schedule. There were references to space, temperature and facilities within the physical environment and several participants spoke about the physical environment when asked what they would change about their work. In addition to the idea of the physical environment being oppressive, there was a strong sense of the unit being a separate entity from the outside world and constantly changing.

#### **Physically oppressive**

When asked what they would change about their work, a number of participants made reference to physical aspects, such as space:

“I’d have a bigger xxx room.” (Z1, 715)

and temperature:

“it’s freezing cold in the winter and it’s absolutely boiling hot in the summer and as much as it’s a secure unit there should be more ventilation and more light.” (AZ, 659-665)

and facilities:

“... just more (.) sort of facilities for the boys...” (Y2, 518)

The interview questions did not relate directly to the physical environment and the researcher wondered why participants made reference to it relatively frequently. It was considered that it might have been a way for participants to talk about a ‘safe’ subject. However because several people made reference to the environment spontaneously it was felt that maybe it reflected the importance of the physical elements due to it being a secure setting.

### *A separate entity*

There was a strong sense for some participants that the units felt like a separate entity to the world outside. Participants described how working within the environment impacted on their relationships with other people. This seemed to be at least partly due to the intensity of the environment. One participant said:

“ Everything ... is more closed in here, you have to work together...there will be more problems than in any other line of work.” (Z4, 602-604)

The notion of the separateness of the unit and the disconnection from the world outside is highlighted by another participant:

“ .... you don't have that much contact with people from the outside world as it were it is very much us and them...” (Y1, 396-398)

There were a number of references to the work inside the units, but little to say how this linked with the young people's lives outside. On the contrary, a number of participants referred to the lack of contact with the young people once they left the unit as though the work existed in a vacuum.

“ ...he's due to go home which is you know a lot of good work by the team ... They don't always want to know what happens down the line [*laughing*].”  
(Y3, 406-414)

There was little sense of how the transition from the unit to the outside world was achieved or how staff or patients experienced this. However there appeared to be a link between this and the theme of engagement and disengagement to which some participants referred when talking about their work with the young people.

### **Continually changing**

Despite a number of obvious mechanisms by which structure was provided on the units, there was a distinct feeling that the work was unpredictable and that the environment was constantly changing. This occurred not only on a daily basis but over time as the units evolved:

“...working with young people you can’t plan your day...” (Z3, 33-34)

One participant described how the young people could be different from one day to the next:

“...you can go quite quickly from one dynamic and one kind of over-riding feeling on the unit to another ...” (Y1, 599-604)

Changes over the longer term were described by different participants. One participant explained that he would have been saying something different if he had been interviewed at a different point in time. He said:

“ ...I would probably have been saying something different...maybe we can identify incidents quickly and deal with them or whether...patients [we] have now [are] different...” (Y2, 593-596)

#### **3.1.4 Negotiating complex staff relationships**

All participants talked about their relationships with other professionals, and this came across as a complex set of dynamic experiences, of which participants were able to provide a range of examples. It was evident that staff had contradictory

experiences of teamwork, experiencing relationships with colleagues as both highly positive and negative. Experiences of authority were largely described as negative. There was an emphasis in participants' accounts of power and a preoccupation with negative appraisal by others. Overall there was a feeling that other staff could be both sources of immense support and strength and sources of disappointment, frustration and anger.

### **Contradictory experiences of teamwork**

This theme came through strongly from participants' accounts. There were references to the team being valued and important and working well, for example: (Z4, 163), (Z6, 504):

“...this is very much a team thing...” (Z1, 285-286)

“ ...we all work very, very well together because at the end we all see the same goals” (Z3, 75-76)

However within participant accounts were contrasting experiences of being part of a team, and this was evident both within professional groups and the wider multidisciplinary team. One member of staff spoke about how she felt towards other members of her own professional group when individuals did not pull together, for example people not volunteering to work over the holiday period:

“At times I feel quite angry towards other people I feel they're very selfish and I don't like selfish people.” (Z3, 499-500)

One member of staff felt that there had been a great deal of difficulty within a particular staff team, to the point where people were openly hostile to each other:

“...for instance you work on a shift with erm staff who probably don’t like each other erm and maybe are shouting at each other at times or not really shouting but making it difficult for each other...” (Y2, 414-416)

Participants also described contradicting views between ground level nursing staff and other professionals, who did not seem to be not perceived as part of the ‘team’.

“ ...the team work with the young people thirty seven and a half hours a week and the other people that come in have an input maybe only do half an hour a week and we see a lot more and we have a lot more awareness of risk and about working with the young people...” (Z3, 89-92)

There was a sense that participants might have had positive expectations or idealised views about teamwork that were not always borne out in reality. For example, the first two quotes imply that teamwork was essentially a positive process. However these statements were somewhat abstract as they did not refer to specific events. When people gave more detail about working within a team, more negative experiences emerged. The researcher wondered whether the idea of a positive team might be another example of a survival mechanism for staff to make it possible for them to remain optimistic about their work.

### *Negative experiences of authority*

Within the theme of negotiating complex staff relationships was a subordinate theme of a negative experience of authority. Whilst there were several references to support being provided by senior staff, the overriding feeling was one of the ‘management’ having different priorities to the staff. It was interesting that participants rarely referred to individuals when talking about their negative experience of authority, but an anonymous collective. It was not clear most of the time which level of management people were referring to, however there was a sense that it was higher management who were perceived as impersonal and unsupportive.

When asked what she would change about her work one participant said:

“What would I change? I’d change the management. Not necessarily the ground management... but... management ethos in the trust and the management culture. I don’t have a model that I would impose or anything like that but currently the management here seems closed off and not that attached, very financially driven and no priority towards patient care.” (Z2, 283-289)

There was a sense that the management could be obstructive. An example was the decision by management to cancel a team event, which staff thought would be useful:

“...after agreeing we could have it and setting a date and a venue and everything just turned around and said actually you’re not having it and that’s what’s hugely hierarchical because actually you know it’s ridiculous because

it's the clinical staff that felt they needed it for support and learning..." (Y1, 179-183)

It was interesting that participants seemed more inclined to speak in negative terms about their experiences of people in authority without very much prompting. There was a sense that this linked closely with the theme of power and powerlessness in terms of the management being viewed as not really involved in the day to day work but having a lot of power.

### **Power and powerlessness**

Closely linked with contradictory experiences of teamwork and negative experiences of authority was a theme of power and powerlessness. A perception of other peoples' power was an interesting feature of this theme. Participants made sense of the hierarchy in terms of length of experience, position in the system and professional role. There was a sense that some staff were not perceived as having an equal voice within the multidisciplinary team and this was echoed by both nursing staff and non-nursing staff

"I get the feeling that the nursing team have to justify themselves...whereas no other members of the team are having to justify their behaviour... I'm starting to think that erm perhaps we're not seen as equals" (Z6, 166-171)

One participant described the power imbalances within her own professional group as going as far as bullying

“...that sign at...the reception door that erm bullying is not tolerated in here then I would say almost every day you can see an example...” (Z4, 743-745)

For one participant the greatest amount of power lay with the psychiatrist

“I always hated the way I think 99 percent of MDT’s work is that you know psychiatrists essentially get to make all the decisions and it’s depending on you know your personal relationships with those people depends on how much you get listened to...” (Y1, 159-162)

In addition to feeling powerless in relation to other colleagues, some participants referred to feeling powerless compared to the young people. One participant described this in relation to one of the young people wanting to move from one ward to another:

“ this young person was making us feel that they had all the power and they could dictate and they could do what they wanted...” (Z3, 146-147)

Another participant had experienced a similar feeling:

“...the young people regardless of what he says is believed before the ward team...” (Z6, 161)

This theme seemed to link to some degree with the super-ordinate theme of managing complex client dynamics. The feeling that some participants described about having less power than the young people and the young people being believed over them was

an example. This highlights that relationships between colleagues and those between staff and the young people might impact upon each other.

### **Fear of openness**

Participants spoke about it being difficult to be open about aspects of their work with colleagues. There were exceptions, where people felt they could be open with certain people, but it was evident that participants felt they had to be careful about whom they shared information with. An example of this was given by a participant who was concerned that people would not understand why she had made a particular decision about how to work with one of the young people:

“I have felt bold enough to share it with someone else, which arguably I should have done before but I still haven’t shared it with the xxx staff cause I feel they would be unsympathetic” (Z1, 692-695)

For one participant it was clear that being careful about sharing information was a significant issue, both in relation to staff and the young people:

“...it’s a medium secure unit, you have to be careful about what you say and what you do” (Z4, 717-718)

Another participant contrasted experiences of being careful about being open in the MDT and being free to be open in her own team:

“...I think lots of people are careful in the way that they communicate with each other in the MDT...whereas with our smaller team ...you don’t have to be so careful and that you can pretty much say what you want to say without that kind of fear of being told off or you know worried that you’re gonna offend somebody because you can actually be quite open.” (Y1, 210-221)

### **Preoccupation with being judged**

Linked with wariness about being open was a preoccupation with being judged. This was clearly more significant for some participants than others. For some the preoccupation was about the judgements of other colleagues but for others it seemed that the judgement was perceived as coming from an external source. In addition one participant expressed concern over whether their interview had been helpful for the research or not, as though they may have been judged negatively by the researcher if it was not.

Some examples where participants expressed concern about being judged by external sources were as follows:

“...the very fact that some person is going to come in and is going to judge what I’ve done...” (Z1, 362-366)

“...blame culture ...defensive medicine...” (Z2, 73-76)

Other examples related to being judged by others within the unit:

“I felt as if everybody’s scrutinising [me] and at times I’ll be honest with you I still feel like everybody’s watching me...and watch if I crack...” (Z3, 300-302)

### **3.1.5 Managing complex client dynamics**

In addition to complex relationships with colleagues, participants described a range of dynamics they experienced in relation to the young people. Overall there appeared to be a process of engaging the young people at the beginning of their stay and then a process of disengaging with them when they moved on and tolerating the fluctuations in patients’ engagement and disengagement throughout their stay. Staff described attempting to keep the young people engaged in the face of conflicting tasks, keeping the young people secure and somehow keeping an individual focus on each child despite this sometimes being at odds with the demands of the unit. Within the theme of managing complex dynamics, there seemed to be a feeling of being pulled in different directions.

#### **Engagement and disengagement**

There were frequent references to the process of engaging the young people and participants spoke about this as being a significant part of their work, and one into which they evidently put a great deal of effort despite the potential for rejection and disengagement. Disengagement processes in relation to the young people rejecting therapeutic input or moving on at the end of their stay in the unit were described by staff.

An example of the need for creativity when attempting to engage the young people was highlighted by one participant:

“...I can offer it and they can reject it, you’re only obliged to offer and if they reject then it’s for me to do something else...” (Z1, 326-331)

A member of nursing staff described getting involved in lessons to encourage the young people to engage:

“... I normally do part of the lesson cos it means that I’ve to sit and write or whatever. I do that because then it makes the young people engage as well.”  
(Z3, 117-118)

There was a clear personal incentive for some staff to engage the young people, despite this being a difficult process:

“...the young people can be really difficult to work with [*laughing*] erm and hard to engage they’re hard to motivate but kind of the opposite to that is that when you succeed in doing those very basic things it can be a massive reward.” (Y1, 28-31)

Later the same participant gave an example of how engagement and disengagement were an ongoing process, and one that was unpredictable. It was clearly not limited to the start and end of therapy:

“...you can think that you have a good working relationship with some of them...and it’s fine and you feel really positive about...engaging them... and

the next day...you'll be treated completely differently and you'll kind of sit there and think well what was it? Was it me? Did I do something? Did I say something to kind of cause this rift...?" (Y1, 571-578)

Participants described the process of disengagement when young people left the unit and for some this was a way of dealing with the intensity of their attachment to the young people. One participant shared their experience of this process:

"...it's quite difficult cos...they get so attached...they always feel safe when they come in. When they are about to be discharged it's ...quite mixed feelings really and you know but then you always try and detach yourself from that situation...and I know that hurts but that's how I always do it anyway..." (Y2, 244-249)

This theme seemed to overlap with the theme around the unit as a separate entity given the need to engage patients at the beginning of their stay and disengage with them at the end of their stay. Again, there is little sense of a before or after within this process.

### **Tasks in conflict**

There were a number of different aspects of the young people of which participants were required to make sense. Issues around being an adolescent, issues around being unwell and issues around offending and risk seemed to be prominent. There was a clear sense of participants trying to understand their therapeutic and custodial roles in relation to the work. Some participants stated this clearly as a tension

:

“...there is a real tension between (.) that you know what are we, are we therapeutic or custodial?...” (Y3, 176-177)

One participant described the emotional impact of these conflicting tasks:

...recently we had a young person who had been admitted to a general ward because he was fifteen was admitted to a paediatric ward erm however because he was a forensic case he was also handcuffed to the bed and that was a huge thing for our team to deal with kind of emotionally.” (Y1, 359-363)

It was clear that the conflicting tasks required of participants sometimes caused them real dilemmas in their work, and led them to question the priority in terms of the clients’ needs. One participant described how the context influenced his approach to the treatment of the young people:

“I have a patient of mine who doesn’t want to take medication and he’s someone that...I think that if he wasn’t in prison and having to come to hospital that way he probably would still be in the community and...you would be thinking of treating him and engaging him in a very different way...”  
(Y3, 219-226)

This theme seemed to link with the theme of power and powerlessness, contradictory experiences of teamwork, preoccupation with being judged and fear of openness.

Some participants made reference to professional groups not necessarily

understanding each others' perspective or way of working and a difficulty thinking about this together. This fits with the idea that participants within their professional groups were required to make sense of the conflicting tasks they were faced with in the course of their work, whilst negotiating this with other individuals and professional groups.

### **Structure and security**

Examples of the use of security and structure seemed to permeate participants' accounts of working with the young people, and it seemed that this was a form of containment for the young people and perhaps the staff also. Accounts of containing the young people both behaviourally and emotionally were given, and the importance of boundaries to keep people safe. An example of structure and security as opposed to therapy was provided by one participant:

“ I'm beginning to think there isn't very much that anybody could do and that he is so seriously damaged that erm we have to accept that all we're doing now is managing the behaviour and containing it.” (Z6, 58-60)

The role of security and structure were clear in the following examples:

“...you have to sort of engage them more and keep them occupied...if you don't do that then that's where you get all these incidents and things like that” (Y2, 300-302)

“...the young people benefited from having a structure within their day...” (Z1, 121-122)

“.... it’s about making them safe and secure...” (Z3, 191)

Consistency as a form of security was referred to in the following accounts:

...you need people to be consistent. The young people need to know where they stand and that everybody’s gonna do the same thing...” (Z6, 301-303)

“ ...there have to be ground rules...” (Z4, 241)

The researcher was struck by how many references were made to the timetable and the structure for the young people in some participants’ accounts. It seemed that the structure provided the basis for everything else to work. The researcher wondered what meaning the participants placed upon this structure and what it might mean if this structure was not present. It felt as though structure and security were heavily relied upon as a way to keep order in what might be an otherwise unpredictable and chaotic environment.

### **Individual versus the system**

Linked with the theme of having different tasks in conflict was the conflict between keeping the individual in mind whilst meeting the needs of the wider system. Several participants referred to an individual focus being an important part of their work, for example:

“...every kid is an individual so we deal with mentally ill offenders and every kid is different, different set of challenges ahead of them...” (Z2, 201-203)

However there were several references to the conflict between keeping this individual focus in the work with the young people in the face of what participants perceived as conflicting ward, unit or service demands. An example of this can be seen in the following account:

“... instead of taking an individual and seeing what we can do for that individual we’re actually saying well this is what we’re going to provide, let’s fit the individual in.” (Z1, 793-795)

Some participants felt that individuals were allowed to get away with unacceptable behaviour, and that unit rules were not always enforced. This generated strong feelings. One example was provided by a participant who was angry that a young person had been allowed to keep their privileges after assaulting members of staff:

“ ...certain behaviours have consequences and the consequences will be the same no matter who you are, if you do this this is what’s gonna happen to you so you know that and you know that long before you ever go and do any of these behaviours.” (Z6, 229-232)

The researcher wondered whether there was a parallel process in terms of the place of individual staff within the system and how their needs were met. Whilst this was not

identified as a theme there was a sense that throughout the interviews participants were reflecting on the part they played within the system, and how it fitted with other aspects of the system. Themes such as power and powerlessness and contradictory experiences of teamwork reflected elements of this process.

### **3.2 Second Level of Analysis**

There were aspects of the research process that were not captured fully within the themes described in section 4.1. These aspects related to the experience of conducting the interviews from the researcher's perspective, the interactions between the researcher and the units as a whole as well as aspects of the analysis of the interview data. These dynamic processes were interesting and puzzling to the researcher and led her to question what they might be revealing about the work within the units. Figure 2 contains a super-ordinate theme of difficulty articulating experiences within which the subordinate themes of barriers to reflection, avoidance, abstraction and lack of coherence are contained.

**Figure 2. Themes within the second level of analysis**

<b>Difficulty Thinking about and articulating experiences</b>
Barriers to reflection
Avoidance
Abstraction
Lack of coherence

### **3.2.1 Difficulty thinking about and articulating experiences**

During the process of conducting interviews and analysing the interview transcripts the researcher frequently experienced a feeling that something was missing. When participants were describing their work, there was a sense that the way it was being described was missing something out. This was occasionally revealed by participants making a slip in their account or contradicting themselves. In addition the participants' descriptions sometimes seemed strikingly at odds with the experiences of the researcher within similar work settings. Despite a thorough analysis of the data the researcher was left feeling as though she had missed something important, but she could not identify what it might be. When attempting to explain and make sense of this during research supervision the researcher struggled to articulate her thoughts. This was understood as possibly reflecting a difficulty for the participants in articulating their experiences of their work.

### **Barriers to Reflection**

A number of barriers to reflecting on the work within the units at different levels and stages of the research process emerged. At an organisational level it took several months to receive authorisation to proceed with the study at one of the units despite a favourable opinion from the ethics committee. Prior to this, the unit intended to be the initial unit used in the study withdrew their involvement despite having initially invited research involvement. There were also several disruptions at a unit level once the research had started. In particular the researcher noticed that the majority of interviews were disrupted for one reason or another for example starting late, being rushed or interrupted once the interview had started. The disruptions and delays at a unit level were primarily due to participants attending meetings about patients in crisis

and staff shortages. Following a visit to one of the units the researcher's research journal read as follows:

“No space or time. The room this afternoon was freezing cold and noisy and not very private. This morning the telephone kept ringing, fire alarm tests, people needing the room for training before and after the interview. Constant feeling of being interrupted. I felt let down coming such a distance and feeling there was no space to talk.”

Other examples of barriers to reflection were provided at a ground level by participants in their accounts of the work. One participant said:

“...we don't have ...like sort of group reflection sessions that's kind of for nurses...” (Y2, 481-482)

The researcher was left with an impression that it was difficult for staff to find the time to reflect on the work in a meaningful way and that operational aspects of the work took priority over other tasks in the event of a crisis.

### **Avoidance**

Many of the participants referred to people outside not understanding or knowing much about their work and their own reluctance about discussing it. There was a sense that participants avoided getting into conversations about their work with people outside of the unit:

“I say that I’m a psychiatrist and that usually stops it...they don’t want to know any more than that...” (Y3, 273-274).

“...me friends erm at times fascinated but to be honest with you I don’t talk about it, they know what I do and that’s it...” (Z3,

Avoidance of talking about the work in a meaningful way was a feature of the research interview for some participants. One of the interview transcripts provided very little detail about the impact of the work, with the exception of staffing problems and operational crises. Attempts made by the researcher to get beneath this were not particularly effective. The same participant also had to leave the interview early due to an incident with a patient. There was a sense that there was not much of an emotional connection at all for this participant during the interview and that the interruptions made it feel safer for both the researcher and the participant to engage only on a superficial level. The researcher experienced this feeling during other interviews and this was primarily with staff in senior clinical or management positions.

### **Abstraction**

Some of the language and examples used by participants seemed abstract and removed from real experience. For example, when asked what participants thought the purpose of the unit was, they tended to give general and rehearsed explanations such as :

“...it’s a medium secure unit...we assess, treat and then move onto (.) where the next appropriate step is for the young person... we do work around mental health issues as well as offending behaviours erm and we to an extent we do some degree of rehab...” (Z5, 479-483)

This type of abstract answer was a common response to this question and presented an intellectual and general account of the work, as might be found in a mission statement. Even in relation to individual patients, this abstract quality was sometimes apparent for example when asked to describe why particular patients were on one participant’s mind he said that they:

“...exhibit behaviour that generally warrants erm staff attention... they...are most likely to have an increase in their observation levels because of their behaviours and the risks they pose to themselves and others.” (Z5, 122-125)

The language here is impersonal and one step removed. This type of bland account of the work was very much at odds with what the researcher had experienced working in adult forensic settings. It was also at odds with some other accounts, which had a more personal and emotional quality. The researcher wondered whether this type of safe response protected participants from having to attempt to wrestle with what might be quite a complex range of purposes served by the units within which they worked.

### **Lack of coherence**

Within the theme of lack of coherence were participants' contradictions, slips of the tongue and minimising complexity. The researcher noticed how some participants' accounts contained ideas that were at odds with each other. Two of these stood out in particular. The first example shows the participant holding what appear to be two different positions within the same example. It was difficult to comprehend that being constantly on call could fit with leaving work anxieties at work:

“I’m on call twenty four seven for them essentially, my mobile phone stays with me whatever and charges up beside my bed at night and I wake up in the morning and put it in my pocket and it never leaves my side...Err but I’m able to kind of leave work anxieties at work and um I think that’s what I need for survival.” (Z2, 125-129)

The same participant made a slip when talking about managing work-related anxiety. It seemed likely this participant had intended to say ‘work’ but had said ‘home’ instead, perhaps revealing that what was being expressed at a conscious level did not reflect what was happening at an unconscious level.

“...if you kept that in mind and weren’t able to leave that at home you just wouldn’t be able to function...” (Z2, 153)

Another participant provided an account of his feelings about nursing staff’s position within the multidisciplinary team, which was contradictory and highlighted a lack of coherence in the participant’s account:

“ I think this is about nurses not the rest of the multidisciplinary team...I do have a very good relationship with the multidisciplinary team which I think is rare in most places erm you know we are given a voice and that voice is equal to anybody elses voice...” (Z6, 135-139)

Moments later the same participant said:

“I never thought I would say this in my career as a nurse but they’re seen as a second class citizen which I think is unfair...” (Z6, 141-142)

Minimising complexity was evident in some participant accounts of the work, and this was understood as a means of avoiding the complexity of their relationship to the work. One participant demonstrated this in the following statement:

“...for me to be honest...the job itself is not difficult at all it’s it’s easy” (Z4, 376-377)

Later the same participant said:

“...I don’t know how I survive...” (Z4, 755)

If the work was as easy as the participant originally suggested, it seems at odds with the later remark. This contradiction suggests the participant does not have a clear sense of how he feels about the work. The participant seems to have recognised the

dissonance between his views of the work and attempts to make sense of this at the end of the interview:

“It er sounds negative er but I would say ninety percent of the job is wonderful, it’s great only it’s saying with the ten percent it’s overshadowing the other ninety percent...” (Z4, 737-739).

#### **4. Discussion**

The aim of the current research study was to explore the experiences of staff working with adolescents with forensic and mental health needs in a secure setting. The results suggested that the staff faced a complex set of processes within their work environment, which impacted on their work and on them personally. The themes which emerged from the research are discussed in relation to previous research and relevant theory and ideas for future research. This is followed by a consideration of the clinical implications and conclusions from the research.

##### **4.1 Interpretation of Results**

###### **4.1.1 Powerful internal experiences**

Some participants described a range of powerful internal experiences in the course of their work. There was a sense that the work had some level of emotional impact on them and at the extreme some participants felt they had lost something of their professional role or identity as a result of specific incidents at work. Conversely some participants spoke in a way which indicated they were not troubled by the work, and that it was possible to avoid feeling anything by the use of protective strategies.

Psychoanalytic literature has highlighted that staff working with people who have pervasive social and psychological difficulties will be profoundly affected by their work. Often this is at an unconscious level (Winnicott, 1949). The notion of staff having powerful internal experiences fits closely with findings from previous research with staff in both physical health and forensic and mental health settings. Menzies-Lyth (1959) highlighted that nurses are confronted with a work environment, which arouses very strong and mixed feelings such as pity, compassion and love; guilt and anxiety; hatred and resentment. Whilst Menzies-Lyth's (1959) study took place in a physical health setting, similar feelings are likely to be aroused in a range of nursing settings.

Jeffcote (2005) found that staff working in a forensic mental health setting described being emotionally affected by patients, for example, in relation to the level of difficulties experienced by the patients. Clinical levels of emotional distress have been identified in staff working with vulnerable and traumatised children (Cornille & Meyers, 1999) and burnout has been identified as a potential outcome for staff who experience a high level of distress in relation to their work with traumatised children (Azar, 2002).

Kurtz (2002) stated that workers will often find it hard to acknowledge the difficult and painful feelings which emotional contact with the experiences of serious offenders arouses out of concern as to whether they will be able to cope with such feelings. The notion of staff defending themselves against the anxieties inherent in this type of work has been described in previous literature, for example Hinshelwood (1993) described how the environmental culture within a prison existed in order to

alleviate the personal distress of prisoners and staff by supporting individuals' psychological defense mechanisms. Dartington (1994) suggested that the intense emotions aroused by working in 'humane' institutions are often contained by those working most closely with patients so that the organisation can experience an emotion free zone in which to operate. Denial, splitting and projection are described as means by which emotionality in the workplace are managed. Further research into the ways in which staff members protect themselves from the emotional impact of their work within FCAMHS services would be very interesting, given the findings of the current study. In addition, some consideration of defences within the wider system would usefully inform practice. An observational study would help to explore these issues further (e.g. Donati, 1989; Goodwin & Gore, 2000).

#### **4.1.2 Impact of the environment**

Participants described their working environment as having an impact on their experiences of their work, in particular finding some of the physical aspects of the environment such as extremes of temperature and lack of facilities; the degree to which the units seemed like separate entities to the world outside and the feeling that the environment was changing continuously. The impact of physical surroundings for staff in mental health settings has been reported in previous research, for example experiencing poor ventilation and high levels of noise (Dallender et al., 1999). Stress emanating from the physical environment has been significantly associated with increased levels of emotional exhaustion (Stordeur et al., 2001).

Jeffcote (2005) found that staff in a forensic mental health setting felt separated from the outside world and that the boundary between the secure setting and the outside

world was a problematic area of thought and transition. Similarly, Kurtz and Turner (2007) found that the staff within their sample felt distant from the hospital within which the secure unit was situated and that relationships with the outside world were problematic. This fits closely with some participants experiences of being in a self contained unit within a wider hospital setting, particularly how patients are viewed by people outside. Regarding the idea of the unit as a separate entity Jeffcote (2005) reported that staff in a forensic mental health setting made very little reference to either the past or future of clients when talking about their experiences of their work. The researcher noticed this in the current study, in particular an apparent difficulty for some in thinking forward to the future of the young person beyond the unit. The researcher wondered whether this might be either (a) a way for staff to distance themselves from the young people as people with a past and a future, with families and a life outside the unit or (b) an anxiety about what might happen in the future, and whether or not the time in treatment had brought about change in the young person. Future research might usefully tap into these concepts in more detail.

#### **4.1.3 Negotiating complex staff relationships**

Staff had to negotiate very complex relationships within their work environment with colleagues and authority figures. Participants spoke about being part of a team as a positive experience in one sense, but there was also a strong sense that working with other professionals represented a source of conflict and potential stress. This supports findings from previous research in forensic and mental health settings and in relation to working within multidisciplinary teams in general. Research has found that support from colleagues is an important factor in reducing burnout in mental health nursing (Melchior et al., 1997). However conflict as inevitable within teamwork has also been

widely reported in a range of settings. West and Poulton (1997) found that primary mental health teams scored significantly lower on aspects of effective team functioning than a range of other work settings because they could not develop clear, shared objectives. Shared values improves teamwork (Waugaman, 1994 cited in McCallin, 2001), but different professionals are likely to have different values, for example Wilmott (1995) found that nurses values included individualism, caring, autonomy, holism and patient wellbeing, while social workers valued collectivity, equality and justice. This highlights the difficulty faced by professionals who have the task of working together, when their aims and goals may not be entirely compatible.

In terms of the specific difficulties experienced by participants in relation to colleagues, the fear of openness has been reported elsewhere, for example Kurtz and Turner (2007) reported that open communication was seen as important for both staff and patients, but as in the case of the current study concerns were expressed as to how possible it was to really talk openly with colleagues. There was a fear that by expressing difficulties openly, the sense of a 'good team' might be disturbed and that challenging colleagues would be perceived as an attack. Jeffcote (2005) also reported that whilst open communication was regarded as important it was mentioned more in relation to its absence than its presence. The issue of power differences between individuals and professions was also reported by participants in this study and was highlighted by Stokes (1994) as an aspect of working within psychiatric settings. He suggested that a focus upon power and powerlessness is a defensive shift away from the real powerlessness the whole team shares in its relative inability to 'cure' the patient.

In the current research the theme of negotiating complex relationships with colleagues came across as one of the most powerful and seemed to the researcher that these dynamics could have a significant impact upon staff in these settings due to the closed environment and the need to work closely with colleagues and rely on them in certain situations. Further research considering the wider systemic issues that operate and impact upon staff relationships would be very interesting.

#### **4.1.4 Managing complex client dynamics**

Participants in the current study reported a range of complex dynamics in relation to their work with patients, for example the experience of engagement and disengagement with clients, seemingly conflicting tasks in relation to the young people, an emphasis on structure and security and difficulty focusing upon the individual whilst attempting to meet the expectations of the wider system. The dynamic nature of clients' engagement and disengagement may relate to their disturbed attachment experiences. As stated by Adshead (2002) the attachment experiences of patients within forensic settings may be particularly important for understanding how the patient relates to both fellow patients and professional caregivers. Winnicott (1949) highlighted the particular challenges inherent in working closely with patients who have had deficient or distorted early experiences. Processes which would usually occur within a parent child relationship may be played out between young people and staff.

Previous research has identified the inherent challenges faced by staff in secure psychiatric settings in terms of the potential conflict between roles. Menzies-Lyth (1979) highlighted the difficulty for 'people-changing institutions' in effective task

definition. She suggested that having multiple tasks, inadequate resources for the task and difficulty in precise definition could all contribute to difficulties performing tasks effectively and achieving satisfaction from such. Settings such as those included in the current study are given the task of working therapeutically with children who have a range of needs, whilst containing their disturbance, protecting them from others and keeping others safe from them. Given these potentially conflicting tasks it is not surprising that some degree of conflict was reported. This type of conflict has been reported by Adshead (2002); Morris (2002) and Kurtz (2002) in adult forensic settings.

The use of structure and routine in the current study seemed to fit with secure services generally and particularly in secure services for young people (Epps, 1994). In the current study there was a sense that the young people could be unpredictable, and that operational and practical processes were important ways of keeping order. The researcher wondered whether the structures and routines helped to alleviate anxieties about the young people getting out of control. As stated by Hinshelwood (1993), who described the experience of being a psychotherapist in a prison, a general atmosphere of well ordered routine covered the undercurrent of menace. Lynch et al. (2005) suggested that when safety concerns loom large, behaviour management may become more salient than therapy.

#### **4.1.5 Difficulty thinking about and articulating experiences**

The current study highlighted that it was difficult for some staff to really find a space to think and talk about their work in any depth. This seemed to be at both a practical

and an emotional level. There was a tendency for participants to provide impersonal and abstract descriptions about their work and there was evidence of contradictions and lack of coherence in some participants' accounts of their work.

Kurtz (2002) found it was uncommon for staff within a regional secure unit to stop and think about practice and in the face of changes to the service. As changes occurred within their service, increasingly concrete metaphors were used to describe practice. Jeffcote (2005) reported an interesting similar finding in a study with forensic mental health staff. It was noted that when talking about patients, who participants saw as challenging their professional aim and personal desire to bring about positive change, that participants were most likely to use neutral, professional language. This was also apparent in the current study, in particular in one participant's account of a client who was on his mind because of the challenges he posed to the management of the unit. The researcher wondered whether the most complex issues within the work were the most likely to be described in a neutral and impersonal way. This would potentially serve as a way of protecting staff from really having to be in touch with the most anxiety provoking aspects of the work.

Using a psychodynamic framework provided some ways of understanding the processes observed by the researcher both at an individual and organisational level during the research. As suggested by Moylan (1994) individuals and organisations may not be able to clearly state what the problem is, or what they might need help with. The researcher noticed that the participants in the sample were not saying they needed help or were really struggling with the work, although this was more obviously the case for one or two participants who had experienced a distressing

event at work. However, given the context, and the client behaviours being described it did not make sense to the researcher that people would not be affected by the work. An over-riding feeling for the researcher was that there was something missing, and that the blandness of some descriptions did not fit with some other participant accounts and her expectations or experiences of working in this type of setting. The researcher questioned whether this was her imposing her own experiences upon the participants and looking for something that perhaps was not there. However it was felt that this might have been a counter-transference reaction to participants' resisting her attempts to access more personal material. This was borne out on occasions where the researcher felt that participants were utilising techniques to keep her at a distance, such as laughing at certain questions or being rather dismissive.

Another frequent experience for the researcher throughout the analysis and interpretation of the results was a difficulty engaging with the material and feeling very overwhelmed by it. Through discussion in supervision, this was understood as a potential counter-transference, reflecting something of the struggle that the participants may have been having in engaging fully with the process of thinking and discussing their work.

#### **4.2 Methodological Issues**

The current study was explorative and findings cannot be reliably generalised to other settings. Larger scale questionnaire based research would be useful in future to identify how generalisable the findings from the current research might be. In addition nursing staff were the largest group in the sample, and it must be considered that the themes that have emerged might say more about their experiences than other staff.

Therefore it would be very interesting to consider differences and similarities between different professional groups.

The reliance upon self-report can be problematic in terms of achieving an objective picture. Using observations would have been an interesting additional component to this research and would have added more depth to the discussion of relationships and cultural and organisational dynamics. However a significant strength of the study was the use of techniques within the interview to attempt to get beneath participants' well rehearsed or generalised narratives about their work and the use of pilot interviews during the development of the interview schedule. Despite attempts to overcome these defensive interview characteristics they were still observed to have occurred to some degree. This suggests that additional development of an interview schedule might be useful in future studies of this kind to compensate for these. Originally it was considered helpful to include young people in the current research. However this was not pursued for a number of clinical and ethical reasons. Ideally, future research would include young people, either through observations or interviews. This would add an interesting and relevant additional dimension to the findings.

### **4.3 Clinical Implications**

There are a number of clinical implications linked with the findings of the current research. Given that young people in secure mental health settings are vulnerable, and have a range of needs it is imperative that they are provided with the best conditions for this to be achieved. If staff are not adequately supported or their needs are not recognised this presents a significant problem. The service developments in this area are still at a formative stage and there is very little previous research to help determine

how to support staff in their challenging and complex work. References were made by some participants to not always feeling supported and lack of opportunity for reflection on the work. This indicates that they may not have much opportunity to process their own feelings and work through transference and counter-transference issues. This has potential implications for the wellbeing of the staff and the patients in the long term. Issues such as burnout and staff sickness may be inevitable outcomes if adequate resources are not available to staff in this type of setting. Despite these challenges, staff viewed teamwork as a positive process and came across as extremely dedicated to doing their best for the young people within their care. They evidently put a great deal of effort into engaging the young people. Adequate support and resources tailored to the environment and client group would be potentially useful, in particular regular opportunities for group and individual supervision and relevant training in the complexities of working with this client group. Ways of supporting staff to communicate openly and develop shared goals would also be beneficial.

#### **4.4 Conclusions**

The current research explored the experiences of staff working in FCAMHS. Participants in the current study indicated that they valued teamwork and engaging with the clients, which was both rewarding and challenging. Some of the challenges they faced included having to negotiate complex relationships with colleagues, patients and management within an oppressive working environment. They also managed a range of difficult feelings associated with the work. Clearly this is a challenging area of work, and there are implications for services if staff are not adequately supported to meet the range of demands placed upon them. This could include opportunities for reflection and training. Further research in this area is

required in order to establish whether the themes from the current study may be generalised to other similar settings. This could be achieved by a combination of qualitative and quantitative research methods to enhance both flexibility and generalisability.

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### **PART THREE: CRITICAL APPRAISAL**

Word count: 3722

## **1. Choice of Research Project**

The original idea for the research emerged through discussions with my field supervisor who had carried out previous research in the area of staff experiences within forensic mental health settings. She already had some contacts within one of the new FCAMHS units, and the idea of carrying out some research had been tentatively discussed with them. However this was at a very early stage and I took responsibility for planning the research from this point. My interest was sparked initially by the research project because it was a subject I found myself feeling as though I could add something to from my own experiences of working within forensic settings. Previously I had carried out research projects suggested by other people, which had not been areas of particular personal interest to me. Whilst I completed these I had found it difficult to connect and engage fully with them. I felt that it would be beneficial to experience what it would be like to be personally interested in the subject of the research and I wondered whether this would have a positive impact on my experience of research. As suggested by Stiles (1993) qualitative researchers often address topics that are personally significant to them and thus involve themselves in self-examination, significant personal learning and change. It is suggested that sharing these processes with readers is important as they constitute a part of the study's observations and interpretations.

An additional reason for choosing the research was that I had not carried out qualitative research before, with the exception of a small part of my undergraduate research project. In hindsight, this bore little resemblance to what I now understand to be qualitative research. I had felt restricted by some aspects of my previous

quantitative research experiences and wondered how I might find carrying out qualitative research.

My previous experience as a forensic psychologist in a prison setting had led me to be interested in what impact working in this type of setting had on staff. Having worked in both a standard prison and a therapeutic prison I was surprised by just how different my experience of working in a therapeutic prison had been to what I had expected. In addition to the immense complexity of the clients, I observed staff members struggling with numerous aspects of the work. Despite the emphasis on ‘therapy’ I was struck by how difficult it was to actually offer this in a consistent manner. Staff shortages and staff opting out of facilitating therapy groups made this a constant challenge. I became aware of just how much this type of work demanded of staff, particularly those in the closest contact with the clients. I felt that an opportunity to carry out some research to make further sense of some of my observations and experiences would be very interesting and worthwhile. I could appreciate the clinical utility of research of this kind having had first hand experience of this type of work.

I imagined that working in a secure setting with children rather than adults, would potentially present some similar but maybe also some different challenges to staff. I found there was a lot of research identifying the nature of problems experienced by young people in secure settings. However I was surprised at just how little research was available regarding staff experiences of working with them. I wondered why this was the case given it was such an important area of work.

## **2. Developments in Methodology and Design**

Initially I had planned to include a focus group with some young people in the study, so as to incorporate their perceptions and experiences of the setting and their experiences of staff. Young and Barrett (2001) identified the importance of considering ethical issues for marginalised children, and found that conducting research with such children both raised and resolved ethical dilemmas. I had found it difficult to have a clear idea of how to incorporate the views of young people in the research. This was reflected in my first ethics application, in which the details about their involvement had been somewhat vague. As a result the ethics committee did not approve the project on the basis of a lack of detail about how issues such as capacity and consent would be dealt with. They also considered the use of a focus group with young people to be potentially problematic. Some of my difficulty thinking about the practicalities of including the young people, was partly related to staff in one of the units voicing strong concerns about including them. It was thought that at the time there were very few young people who could participate due to their mental state. Whilst I could have pursued this, it was decided through discussions with my field supervisor that staff were the main focus of the study, and therefore it might be more useful to put the time and effort into planning a strong study with staff. This was largely influenced by the time constraints of the doctorate and the fact that I had to re-apply to the ethics committee.

This experience highlighted that the inclusion of vulnerable or marginalised individuals is an inherent problem in research. Whilst protecting participants from harm is of paramount importance, this created a tension for me, as I was left feeling uncomfortable that there was a risk of increasing the marginalisation of some groups

of people if they were not included in research. This demonstrated for me the importance of detailed and thoughtful planning when considering using particular groups of people in research. Despite this, on reflection I considered the number of participants to be ample for the requirements of the doctorate research study. I thought I might have struggled to manage this additional strand had I pursued it.

My choice of methodology was one which involved a great deal of thought and deliberation and I eventually chose IPA over Grounded Theory. I attended seminars by Anna Madill and Mike Osborn, and used these opportunities to find out as much as possible about different approaches in order to make the decision. On balance IPA seemed more appropriate for the study. The main reasons for this were that IPA seeks to describe rather than explain (Jeffcote, 2005) and this seemed appropriate given there was not a specific research hypothesis. In addition, given what I understood about forensic settings it was felt that by combining “an empathic hermeneutics and a “questioning hermeneutics” I could attend to both direct and indirect communication by the participants (Smith & Osborn, 2003). One aspect of IPA which could be questioned in relation to this study is its assumption of the sample being a homogenous group. It could be considered that based on the different professional roles of participants within the sample that the group is not strictly homogenous. I made this judgement in discussion with others based on the staff working within the same type of setting. However I acknowledge that the individual participants’ professional role might impact upon their experience of the work. I am also aware that grounded theory might have allowed for more scope in terms of considering group psychological processes or development of a group or organisational model. This could have been an interesting idea to consider but it may be that this is more realistic

as a next step. Given that this study was intended as very open and exploratory in nature, I still consider IPA to be the right choice of methodology overall.

### **3. Conducting the Research**

Conducting the research seemed to be characterised by a series of delays. The initial unsuccessful ethics application caused a delay of several weeks but this was less significant than the delay caused by the process of gaining approval from the local Trust Research and Development (R&D) department at the second unit. Having carried out the first set of interviews at the first unit with no issues raised by the Trust R&D department I was surprised by the lengthy and rigorous procedure employed by the second Trust R&D department. I was required to undergo a lengthy peer review, after which I was provided with a list of suggested amendments to the study. As I had already had ethical approval it was not appropriate to make any changes to the study. It seemed that the peer review process was somewhat at odds with the ethical review process. The main reason for choosing to submit the study to a multi site ethics committee was that it should have been the most efficient way of ensuring access to more than one unit. Therefore it was hard to comprehend that it may have been quicker to apply to the individual local ethics committees at each site.

The reaction to the research at individual sites was very interesting. The research was due to start at a different unit initially. An agreement was made in principle at an initial meeting. I subsequently attended a second meeting, and nobody attended. It seemed that it had been completely overlooked but I was given no real explanation about this. Another unit was agreed and the arrangements seemed to flow with ease. The liaison person at this unit made sure that my request was efficiently dealt with

and my visit was arranged with little discussion. Interestingly, despite being easy to get into the unit, it did not feel easy for some participants to find space and time to talk. I got the impression that I was initially seen by some participants as someone who had come in to learn about the service and that it was their job to tell me information about it. I did not pick up on particular anxieties about research, more that it was something of an inconvenience in the face of challenging operational and clinical responsibilities.

The second unit seemed much more cautious in their approach to the research and a meeting was arranged with the research committee. Initially several methodological questions were asked, which seemed to reflect anxieties about the research, for example how would I ensure a 'representative' sample so as to prevent only interviewing participants with a particularly negative view of the work. I was also asked why I wanted to do this research when there was already a lot of research into adolescents with mental health needs. I felt as though I had to work quite hard to get across why I thought the research was worthwhile during this meeting. Towards the end of the meeting the committee member who had seemed to have raised the most concerns said "it's nothing really is it?" I was left very puzzled by this as it seemed at odds with the mood of the meeting and with her concerns up to that point. I have reflected on these experiences since. On one hand I have wondered if it is a straightforward case of staff in the units being busy and not having time to prioritise my research. On the other I wonder if this reflects discomfort at an individual and organisational level with the idea of being the subject of research. The second explanation would fit with previous researchers' impressions of research within psychiatric and forensic settings (Goodwin & Gore 2000; Jeffcote, 2005)

#### **4. The Interview Process**

I found the research interview difficult to adapt to, and at times I was aware of preventing myself from treating it as a clinical interview. I felt that my limited previous experience of qualitative research may have had an impact upon my confidence in this area. Initially I found myself wanting to make the questions seem less direct, and sometimes asked more than one question at a time, with less clarity than I would have ideally liked. I discussed this in supervision, which helped me to be aware of how my use of words could potentially reduce the power of what I was asking people. There was a sense that on some level I may have wanted to make things easy for the participant by dampening down the questions to some degree. I found that this improved as the interviews progressed and my confidence grew.

The interview process seemed difficult with some participants and easier with others. As suggested by Holloway and Jefferson (2000), this could have been influenced by either defences employed by participants or by myself (or both in some cases). Some interviews seemed to flow less easily because of what I considered to be defensive practices employed by participants. I got the impression this was not necessarily a conscious process. An example of this was an interview where the participant came across as very cautious and measured in how she answered my questions. I also noticed that this participant laughed after I asked each question. I felt quite conscious of being judged by this participant and found myself feeling defensive and wanting to make sure my questions came across as well considered. I found myself doubting my interview schedule and wondering if I was getting things wrong. I had this feeling on two obvious occasions, with senior clinical staff. I wondered whether there was

something important for me to be aware of in terms of how I responded to interviewing participants, who I perceived to be in a position of power. I also wondered if their role had an impact upon their attitude to being interviewed. Charmaz (2006) draws attention to the importance of power dynamics within the research interview.

Some interviews flowed much more easily, and it felt as though people really were engaging with the questions in quite a personal way. These tended to be longer, and felt less uncomfortable on my part. At times I felt as though I identified with the experiences of some of the participants. This tended to be those who talked about the complexities of the work, or about extreme experiences. I thought it was important to be aware of this, and considered to be an inevitable part of my experience of conducting this particular research study. Throughout the research I kept in mind that my own previous experiences might have been impacting upon how I was interpreting the interview material. In order to address this I was careful to ensure that my analysis and interpretations were grounded in what participants said (Smith & Osborn, 2003). It is not really possible to know how it would have been different or similar if I had never worked in a secure setting. However I believe that it helped me to be empathic and curious about participants' stories, which felt very useful within the IPA framework.

## **5. Engaging with the Research**

### **5.1 Engagement During the Analysis**

As stated previously I had assumed that by researching an area of personal interest I would feel more engaged with the research. Unexpectedly I still experienced some

significant difficulties at times engaging with the research. Whilst this was almost certainly related to a number of other factors, I considered that one possible explanation might be what would be described in clinical work as a counter-transference response. Despite having ensured optimum conditions for analysing the interview transcripts I found it very difficult to stay with the transcripts for very long. I felt I was constantly moving between being engaged and avoiding engagement. I questioned whether this might have reflected something of the experiences of my participants in the course of their work. Alternatively it might have something about my own ambivalence about this type of work. Whilst it felt like quite an arduous process at times, I believe I analysed the interview material thoroughly and thoughtfully. Once I began writing about the themes, it became easier to think about them and I was able to continue to develop my initial ideas as I went along. In addition, the suggestion by my supervisor to verbally explain the analysis and development of my themes was very useful.

## **5.2 Supervision and Reflection**

At times I found myself struggling in supervision to describe what I was finding in my analysis of the interview material. I felt anxious that I was missing something and that if only I could find the missing part it would all make sense. I experienced an urge to start again from the beginning at one point in order to convince myself I had not missed something. Eventually through discussion with my supervisor I reached a point of accepting that this may have been a parallel process and that I was maybe experiencing something of what it is like to work with these young people, or picking up on the difficulty participants may have been having in articulating their experiences of their work. The process of supervision was very helpful in terms of

exploring different explanations for what I was experiencing and making some sense of my reactions to the analysis. In addition, keeping notes at each stage of the research process was helpful as a way of reflecting and keeping in mind some of what I was experiencing at the time. Being part of a qualitative group also helped in terms of sharing experiences with others and gaining different perspectives on these experiences.

### **5.3 Impact of External Events and Personal Experiences on Engagement**

Throughout the research I was aware that there were a number of reasons why I might have been struggling to engage with the research more generally. In addition to my specific difficulty engaging with the transcripts and my feeling that I was missing something I found that my motivation in general fluctuated in response to current external and internal experiences. During the course of the research my father passed away following a protracted illness. I felt overwhelmed at times with expectations relating to my research and expectations related to expectations I had of myself in relation to my family. In hindsight I realised just how much of a struggle this was for me at the time. Although adjusting to the bereavement was a difficult process I experienced a significant shift in my ability to engage with the research once it actually happened.

In addition to the bereavement, whilst carrying out the research I was at the point of considering my future career. Given my experience prior to clinical training as a forensic psychologist I was torn between making a fresh start in a new setting and returning to a forensic service. Having been offered a job in a secure forensic psychiatric setting I was attempting to work through my own feelings about what it

would mean to take this position. I was mindful that not knowing whether I would be returning to this environment might be having an impact on how I was engaging with the research. Eventually I decided that I would not return to a forensic setting, and it seemed that this freed me somewhat in terms of writing up the research.

## **6. Writing Up**

The writing up of the study was a process I found uncomfortable at times. I was very aware that I was writing about real people, and that as such I had a responsibility to do this in a conscientious way. I found it difficult to make bold statements, and at time felt as though I veered towards being over cautious. This was particularly evident in my thinking about maintaining anonymity. I was acutely aware that I did not want individuals to feel exposed, and I wondered whether my decision to only include categories for demographic information was over-cautious.

Another example of my caution was an initial tendency to include a large number of quotes for each theme, as if to confirm that my interpretations were backed up by examples. However this made the results section too lengthy and difficult to read. I then became more selective about my examples, in the hope that it would make it less arduous for the reader. I wondered if this tendency towards caution was an aspect of qualitative research in general or whether it was something specific about my particular study or me as a researcher. I concluded that it was probably a combination of these three factors.

## **7. Conclusions and Learning points**

The experience of carrying out the research has been extremely valuable as a learning opportunity. I feel I have learnt a great deal about myself as a researcher and about the process of carrying out research in general.

### **7.1 Being Prepared for the Unexpected**

One of the most important things I have learnt as a result of my research is that research does not always go to plan and that as a researcher it is important to be able to be flexible enough to adapt to changes and developments during the course of the research. I found that I needed to adapt to things that did not happen as planned, such as participants dropping out, and in my case a whole organisation withdrawing their involvement. I consider the fact that I was able to continue with my research in the face of various challenges and unexpected events to be a significant personal achievement. As a result I feel it has increased my confidence to carry out research in future

### **7.2 Relationship with Research**

My original belief about the likely impact of being personally interested in the area of research is one which I now view differently. It now seems that my expectation of a simple correlation between interest and engagement might have minimised the complexity of the relationship between the researcher and the research. I now understand that my engagement with my research was more complex than I had assumed and dependent upon a number of inter-related factors.

### **7.3 Research Skills**

Using a qualitative approach has renewed my enthusiasm for research in general and by completing this piece of research within the context of a doctorate training programme I consider my research skills and knowledge to have developed significantly. As a result I am certain I would not shy away from research opportunities in future. I would like to further develop the skills I have acquired and consider the contribution to research to be an important role for clinical psychologists. I consider what I have learnt in terms of planning research to be invaluable and having experienced both a successful and unsuccessful ethics application I have a much greater awareness of how important it is to plan research thoroughly and consider all aspects of the research in advance.

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## **APPENDICES**

## **Appendix A.**

### Research Ethics Approval Letter







## **Appendix B:**

Ethics Letter Approving Change of Methodology





## **Appendix C:**

### Participant Information Sheet







**Appendix D:**  
Interview Schedule



**Appendix E:**  
Participant Consent Form



## **Appendix F:**

Notes for authors for target journal 'Criminal behaviour and mental health'

