The psychodynamic approach to observing organisations: towards a psychosocial intervention

Submitted April 2012

By

Emma Tilbury

To The University of Leicester, School of Psychology, Clinical Section,

In partial fulfillment of the degree of,

Doctorate in Clinical Psychology

Declaration

I confirm that this thesis is my original work, except where otherwise stated with reference to the original author(s). It has been submitted in partial fulfillment of the degree of Doctorate in Clinical Psychology and no part of it has been submitted for any other degree or academic qualification

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Section A: Thesis Abstract

A mixed methods literature review was conducted to investigate methods of obtaining process feedback during and after a psychosocial intervention and how this has been used to evaluate the intervention. Twenty four articles were retrieved that met the inclusion criteria. The data were synthesized and critiqued according to methodological features, with limitations evaluated. Results were presented according to how the feedback research has been used in relation to therapeutic outcome and clinical implications were considered. Recommendations were suggested, including investigating long term outcomes where single measures were utilised.

The research study involved a series of six psychodynamic ward observations of an acute inpatient ward. The data were analysed within the supervision group discussions; thematic analysis was conducted on the transcripts (Braun & Clarke, 2006); with further analysis occurring during academic supervision. Five main themes were created to describe the ward culture from the observer's experience, which captured the dynamic processes and relationships between staff and patients. A follow on study is planned which involves presenting the current findings to the staff group in an attempt to validate the observation method.

A critical appraisal is included which describes the researcher's reflections throughout the research process and the impact experiential learning made on her.

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I would like to thank all the individuals on the ward who bravely and kindly allowed me to carry out my observations in their space. I found the experience deeply interesting, fascinating and emotional.

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List of tables and figures

Section B

Critical Literature Review

How has process feedback of a psychosocial intervention been researched in relation to therapeutic outcome?

Prepared for the Journal of Applied Psychology

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Literature Review Abstract

Purpose: The current mixed methods review aimed to systematically review and critique the research literature on *how* process feedback, which focussed on the clients' experience of an intervention has been obtained. The second objective was to investigate how that research has been used in relation to therapeutic outcome.

Method: A computerised literature search was conducted using four key publication databases from 2007 to 2012. Additional articles were identified from previous reviews. Particular inclusion and exclusion criteria were employed. Twenty four articles were reviewed and each was assessed on methodological rigour.

Results: The search revealed benefits and limitations of using different methodologies to obtain feedback and found studies that explored 1) the association between therapeutic outcome and client satisfaction, 2) findings of client progress feedback reported to clinicians throughout a psychosocial intervention, and 3) clients' perceptions and experiences of an intervention.

Conclusions: Findings in the literature revealed the complexity and limits of using one dimensional scales and questionnaires to measure therapeutic change and client satisfaction. Qualitative findings revealed the strengths in eliciting client feedback. The therapeutic relationship was important to monitor the client's progress and inform the therapist of which techniques were suitable to introduce into the therapeutic work.

Keywords: *participant/client feedback; therap* outcome; client/participant satisfaction; psycho* intervention*

Target Journal: Journal of Applied Psychology

1. Introduction

1.1.Background and Context for the current review

1.1.1. Patient[2] experiences.

In a report by Lord Darzi, *High Quality Care for all*, a key focus was to use patient experiences as a guide for monitoring the quality of NHS services (DoH, Understanding what matters, 2009). The aim was to use the information learned from patients to direct and inform future service structure and organisation in an attempt to improve the experiences for NHS patients. As part of the 'Evidence-Based Design' programme there has been an effort for all services to use systematic approaches to capture and utilise patient feedback.

There has been recognition that simple measures of patient satisfaction are limited in what information they can provide in order to inform and monitor change. Boswell, Castonguay and Wasserman (2010) state the nonlinear process of change in individuals in therapy and that interventions that appear less helpful or arouse certain levels of distress can play a pivotal role in positive change. Patient satisfaction can also be influenced by personal attitudes, and past experiences, which makes the task of identifying patient satisfaction complicated (DoH, Understanding what matters, 2009). Claiborn and Goodyear (2005) highlight the complexity of feedback as they state: *'All feedback is based in observation and involves inference. At the same time, feedback can be erroneous and certainly can merit discounting'* (p. 210). Gaining insight into therapeutic processes from client's experiences of therapy has implications for predicting outcomes and efficacy (Elliott, 2008; cited in Anker, Sparks, Duncan & Owen, 2011).

[2] Patient and Client were used interchangeably throughout the document.

1.1.2. Psychosocial interventions and Government initiatives.

The influx of cognitive behavioural therapists (CBT) from government initiatives such as IAPT (improving access to psychological therapies) and Government reforms including 'payment by results' (DoH, 2011) have led to an increasing pressure for clinicians and researchers to investigate the effectiveness of different types of therapies. Furthermore, 'clustering' individuals, as part of the 'payment by results' initiative is being used to decide on an individual's health care pathway throughout their treatment. This means that services are being required to assess individuals to identify specific packages that can be delivered based on their needs. Decisions on clinical need and care should be based on the evidence base available. Therefore, Government plans to use patient feedback to inform commissioners about service structure, and the introduction of care pathways, means that effective and innovative feedback measures need to be created in order to really capture patient experiences. It is important that feedback data is added to the existing evidence base, whilst acknowledging the complexity in interpreting feedback data.

1.1.3. Methods of obtaining process feedback.

Methods of obtaining process feedback, during or after a psychosocial intervention, have included the use of standardised questionnaires; interviews; focus groups and evaluation forms. There have also been developments to include patient feedback in 'real time' so that findings can be assessed quickly and changes implemented sooner, whilst they are still meaningful to the patients. For example, IAPT services use the SRS (session by session rating scale) to collect routine outcome measures to produce electronic data, such as graphs to use in sessions with patients. However, Hodgetts and Wright (2007) found that methodological limitations were obstructing clients' views being accurately captured within

research.

1.1.4. The impact of feedback on the therapeutic process

There is limited research at present detailing the impact on the therapeutic process after clients provide feedback of the session to their therapist. Previous studies of therapeutic outcome focused on the client's experiences of therapy, after the therapy had ended. Some research has been conducted looking at the effects of feedback on the assessment process (Ackerman, Hilsenroth, Baity & Blagys, 2000) and feedback within group therapy (Davies, Burlingame, Johnson & Barlow, 2008). Ackerman et al. (2000) explored the interaction of therapeutic process and alliance when clients received feedback from their therapists, comparing a therapeutic assessment (TA) model (Finn & Tonsager, 1997) with a traditional model of gathering information. The therapeutic assessment model is one which is collaborative and encourages the client to view themselves as an expert on themselves. The results favoured the TA model, where there was a decrease in the number of patients who terminated treatment against medical advice. Patients viewed the feedback session as 'good' when it was related to 'depth' and positivity of the session; and was seen as powerful, valuable and special. There was least relation to 'smoothness', arousal, and feelings of discomfort, suggesting that the clinician did not have to minimize the patients problems for the patient to feel that a session was good (Swann, 1997).

Davies et al. (2008) looked at the immediate and distal effects of feedback directed at both members and leaders of group therapy. The researchers described two separate literatures on feedback; including interpersonal feedback and feedback interventions, which they argued had rarely been integrated. They described the former as being examined as a therapeutic factor and the latter being examined in experimental, social and organizational

literature, as a modification to a process or event. In the experimental condition participants were given weekly written and graphical feedback; however it was found that this had little impact on therapeutic factors and outcome. Interestingly, when members reported that the group was high in conflict, the feedback intervention had a significant negative effect on outcome. Suggested reasons for the findings included the feedback measure being more relevant and familiar to the leaders rather than the members of the group; and that the information shared with the group was general and non-specific, limiting the opportunity to gain interpersonal change about oneself and others. However, the findings also appear to fit with some findings from individual feedback where one third of the interventions using a feedback tool decreased performance. Kluger and DeNisi (1996) have suggested that knowledge of one's performance can lead to a decrease in motivation and engagement when one is doing poorly.

Further research in this area is clearly needed considering the influx of studies using feedback interventions and tools, but with minimal research on how this affects the therapeutic process.

1.2.Definitions

Feedback, according to Claiborn and Goodyear (2005), is '*...defined as a response to an action that shapes or adjusts that action in subsequent performance. Though its pervasiveness in human behaviour is noted, feedback in clinical practice is a deliberate psychological intervention that has two essential functions, information and influence. Feedback can be descriptive, evaluative, emotional, and interpretative"* (p.1).

This definition incorporates the Government initiatives to use patient feedback to

provide meaningful information to local services and commissioners that can subsequently inform and direct future service organisation to improve patients' experiences. It also acknowledges that feedback can be multifaceted and can be approached in various ways in order for it to be meaningful to the research or clinical context.

1.3. Previous Reviews

Previous reviews in the area of 'process feedback' relevant to the current review were found by Claiborn and Goodyear (2005) and Hodgetts and Wright (2007). Hodgetts and Wright's (2007) review of qualitative studies of clients' experiences discussed an increase in studies that explored 'model specific factors' and those that aimed to uncover 'pan-theoretical elements' in order to distinguish differences in therapeutic models (p.158). In Hodgetts and Wright's (2007) review they included studies that had utilised questionnaires and interview methods in order to generate their data (e.g Chiesa, Drahorad & Longo, 2000). The current review varies from Hodgetts and Wright (2007) in that the focus is on *how* process feedback has been investigated and used to evaluate an intervention; rather than focus on the findings of qualitative research *per se* (e.g. process and model variants).

Claiborn and Goodyear (2005) discuss the concept and reciprocal nature of feedback, using research from engineering and cybernetics through to the therapeutic treatment room. The authors illustrate how the therapist can be the receiver of feedback during therapy sessions, by using the clients' outcome questionnaire (OQ-45; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005) that signifies whether a client is progressing as expected and what action the therapist takes as a result. The authors acknowledge that every action, suggestion, cognitive challenge or response the therapist gives to the client is feedback and

affects how they respond and so forth. The objectives of Claiborn and Goodyear (2005) were to define and provide examples of giving effective feedback to individuals; whilst addressing the outcome literature at the time of their review. The authors describe an earlier review of studies investigating therapists providing feedback to clients (Claiborn et al., 2002) but they identified a sparsity of research on feedback as a component part of treatment and focussed mainly on feedback of personality assessments (e.g. Finn & Tonsager, 1992).

1.4.Aim of the Review

The aim of the current review was to systematically review and critique the research literature pertaining to the use of 'process feedback' during and after a psychosocial intervention to explore how this has been used to evaluate the intervention. The objectives of this review were: 1) to determine what methods are currently being used to investigate process feedback related to therapeutic outcome; and 2) to determine how this feedback is being used to evaluate interventions.

2. Method

A systematic review of the literature surrounding process feedback and therapeutic outcome was carried out using the main psychological electronic databases (PsychINFO, Science Direct, Scopus, and Web of Science) from 2007 to 2012. In addition the Cochrane Database of Systematic Reviews was also searched. Titles and abstracts were scanned and relevant articles were selected for further analysis using exclusion and inclusion criteria. Finally the reference sections of relevant articles were scanned to find further potential studies and to provide a larger scope of the surrounding literature. Appendix B illustrates the search strategy involved. The key words used for this search are displayed in Table 1.

Table.1 *Search Terms*

	Search terms (1, 2 and 3 combined with 'AND' syntax)
1	'Client' or 'participant' or 'individual'
2	'therap*' or 'treatment outcome' or 'satisfaction' or 'feedback' or 'experience*'
3	'psycho* intervention' or 'psychosocial' or psycholog*

All articles were combined in a reference management database (Refworks) and any duplicates were removed. Following this a systematic review of each relevant article was undertaken using a data extraction pro-forma. Each article was rated on the aims, methodology, sampling methods, participants and sample sizes, control groups used and reliability and validity of the results. Downs and Black's (1998) checklist for the study quality of quantitative articles was used as a guide and specific features identified were reported in Appendix D. Morrow (2005) and Stiles (1993) have reviewed the criteria for

selecting and appraising sound quality research in qualitative studies; their criterion was used as a guide to appraise the relevant studies in the review (Appendix E). A table of the methodological features of included studies is found in Appendix F.

Inclusion Criteria: The Papers selected for review were those whose primary aim was to gather feedback from clients in a way that could enable the investigator to evaluate the intervention. Articles published between the years 2007 – 2012 were included to keep the review as contemporary as possible. Qualitative studies were included if methodologically rigorous and if a known qualitative approach had been employed.

Exclusion Criteria: To find relevant articles for the review, the searches were limited to peer reviewed journal articles written in English, relating to adults and due to time constraints were those that were easily obtainable either through Athens or the University Library. Chapters, dissertations and meta-analyses were excluded as were theoretical and opinion papers, and case studies. Sample sizes of less than 8 were excluded to ensure studies had some degree of generalisability.

Data Synthesis

The search yielded 62 articles, of which 38 were then excluded on the grounds given above. Based on the data extracted from the articles, the information was synthesised into a summary table and a narrative of the findings were described within the results.

3. **Results**

Twenty four articles were found to meet the selection criteria and were included in the detailed critical review, 18 quantitative and six qualitative (summaries and descriptions of the reviewed articles were included in Appendix F). Of the quantitative studies identified the results are reported according to those articles that were related to 'therapeutic outcome' (11) and those that were identified as 'progress feedback' (7). All methodological and study details of the articles are in the Appendices (D-F), including a quality appraisal.

3.1. Methodological Features of Studies of Therapeutic Outcome

The sample sizes of individuals in these outcome studies ranged from 42 - 742. The total number of participants was 2266, and the majority were female (75.8%; two studies were 100% female and one study was predominantly male [67.6%] within an alcohol setting).

3.1.1. Study design.

The studies utilised the following designs: longitudinal (Botella, et al. 2008); pre-post tests within subjects (Defife, Hilsenroth, & Gold, 2008; Lunnen, Ogles, & Pappas, 2008; Boswell et al., 2010); pre-post tests between groups (Murphy et al., 2009); secondary analysis from an RCT (Ogrodniczuk;, Joyce & Piper, 2007; Manne et al., 2010); cross sectional (Orford et al., 2009; Owen, Wong & Rodolfa, 2010; Magill et al., 2010); and an RCT (Andersen, Shelby & Golden-Kreutz, 2007). Only four studies described randomising clients into intervention groups, (Orford et al., 2009; Andersen et al., 2007; Manne et al., 2010; Magill et al., 2010) and only the latter two stated how they did this. Other factors included therapist availability (Defife et al., 2008); the prevalence of a significant other (Magill et al.,

2010); or participant's choice (Murphy et al., 2009). Recruitment methods included opportunistic methods such as those participating in therapy (e.g. Botella et al., 2010; Boswell et al., 2010; Lunnen et al., 2008) or attending other outpatient services (e.g. Ogrodniczuk et al., 2007; Magill et al., 2010). The generalisability of the findings to diverse or ethnic groups was questionable due to the predominantly Caucasian population investigated (84% in the seven studies that did report this factor).

3.1.2. Sample sizes.

The majority of the studies reported data based on small sample sizes, particularly towards the end of the intervention where attrition rates were high (e.g. Botella et al., 2010). Power was also reduced in studies where there were uneven numbers of participants in either group (Murphy et al., 2009) and where two intervention groups had to be combined during the analysis to look at non specific therapy processes due to inadequate sample sizes (Manne et al., 2010). In contrast, Orford and colleagues (2009) reported a sample size of 742 participants with retention rates of 95% and 83% at three and twelve month follow-up respectively. Also, Andersen et al. (2007) reported findings that had increased statistical power due to a large and homogenous sample, with 93% retention at 12 months follow up.

3.1.3. Intervention length.

Intervention length was infrequently stated and ranged from three sessions of motivational enhancement therapy (MET; Orford et al., 2009) to three years of ongoing therapy within a naturalistic setting (Botella et al., 2010). Lunnen et al. (2008) included individuals and their spouses and sessions ranged between two and 31 sessions. Participants in Owen et al. (2010) completed an average of five sessions. Studies where two interventions

of different lengths were subject to comparison was problematic and made the findings less reliable (Defife et al., 2008; Murphy et al., 2009; Orford et al., 2009; Magill et al., 2010). Andersen et al. (2007) reported that attendance did not differ between the treatment and TAU cohorts, and was the only study to include a maintenance phase, which involved a total of 26 group sessions over a period of eight to twelve months after the more intense phase of weekly sessions initially.

3.1.4. Methods and timing of obtaining feedback.

The studies were largely based on using standardised and validated measures to collect participant feedback. The exceptions were studies that used measures not yet validated (Murphy et al., 2009) or their reliability was not stated, having been designed for the purpose of the study (Magill et al., 2010). Measures were predominantly investigating outcome associated with client perspectives on: (dis)satisfaction (Lunnen et al., 2008; Murphy et al., 2009; Ogrodniczuk et al., 2007; Andersen et al., 2007); therapeutic alliance (Botella et al., 2010; Magill et al., 2010; Manne et al., 2010); specific intervention techniques (Defife et al., 2008); perceived level of change (Lunnen et al., 2008); and the quality of the therapeutic experience (Boswell et al., 2010). Methods other than questionnaires or Likert scales included open ended questions, for example "what did your therapist do to help you change?" (Owen et al., 2010); and sentence completion, for example "The most/least useful thing about today's session was?" (Orford et al., 2009). Measures were most frequently collected throughout the course of therapy; however Owen et al. (2010) collected data retrospectively (up to three months) after the treatment had ended. Hill and Lambert (2004) have argued that measuring outcome at termination is too distal in relation to certain processes.

3.1.5. Fidelity to a manual and training.

Of the eleven studies, six (Andersen et al., 2007; Defife et al., 2008; Ogrodniczuk et al., 2007; Boswell et al., 2010; Manne et al., 2010; Magill et al., 2010) used a manual to guide the intervention. However, in some studies therapists were not prescribed to act according to the manual (Defife et al., 2008) and could be flexible (Magill et al., 2010); whereas other therapists were monitored with checklists to ensure treatment integrity and consistency (Manne et al., 2010; Andersen et al., 2007). Therapists received weekly training (via video feedback or seminars) to deliver the intervention in five of the studies reviewed (excluding Manne et al., 2010). In the other studies reference to training and experience using interventions was stated although details were not provided (e.g. Orford et al., 2009). In contrast Botella et al. (2010) stated only that individuals were treated in a psychotherapy service but not what the therapeutic technique was that was under investigation.

3.2. Results

3.2.1. Satisfaction and symptomatic change.

Client satisfaction and symptomatic change have been commonly investigated as a measure of service evaluation due to their high face validity, ease of implementation and positively skewed results (Lambert & Ogles, 2004). However, Hayes (2007) points out that interventions or experiences that appear less helpful or lead to symptomatic deterioration can be part of eventual positive change. The findings on satisfaction and symptomatic change were complicated, in part due to the limits in the measures used and the different approach by each study in delivering the intervention and obtaining the feedback (see the above sections). Lunnen et al. (2008) did not find a relationship amongst satisfaction and symptomatic change, suggesting that assumptions about symptom reduction and increased satisfaction may not be

empirically supportable. Lunnen et al. (2008) suggest that satisfaction measures are problematic as they are largely global and instruments need to allow space for reporting dissatisfaction. Ogrodniczuk et al. (2007) compared interpretive and supportive therapy on levels of dissatisfaction with the therapist and found that although dissatisfaction was higher in interpretive therapy it had minimal impact on outcome, whereas it had a considerable impact when found in supportive therapy. The authors considered the purpose of interpretive therapy to induce an atmosphere of anxiety and the benefits of discussing difficult feelings as they arise. In contrast, feelings in supportive therapy may be suppressed until the end of therapy where the support and attachment to the therapist is no longer needed. Andersen et al. (2007) found that satisfaction within a group of patients with cancer was significantly associated with feelings of group cohesion and that although satisfaction was important patients' feelings of support and connection with the group were related to better outcomes. Andersen et al. (2007) also found that occasionally those who had higher symptoms at baseline showed the greatest rate of improvement (lowest level of symptoms compared to those who had a lower baseline) by the 12 months follow up, which they suggested was due to individuals being vigorous users of the intervention component. In a similar vein, Botella et al. (2010) found that less symptomatically serious cases were more likely to relapse because their presenting complaint might not be focussed on symptomatic alleviation. Therefore, more comprehensive methods of obtaining client perspectives on satisfaction and dissatisfaction in therapy should be sought, including attempts to gain information on long term outcome.

3.2.2. The therapeutic alliance and therapeutic technique.

A view that non- specific 'common factors' (CF) are the underlying mechanism of

change in psychotherapies is growing (Imel & Wampold, 2008). However, Botella et al. (2010) and Manne et al. (2010) in the current literature review explored some of the different definitions associated with CF, therapeutic alliance and bond, highlighting that instruments were measuring different aspects of these concepts, therefore limiting generalisability across findings. In contrast other researchers were seeking methods to investigate specific techniques and how clients perceive these being used in the session (Boswell et al., 2010).

Botella et al. (2010) found that alliance was crucial in predicting outcome, in terms of a reduction in clients' symptoms and an improvement in subjective well being. Owen et al. (2010) found three clusters of clients based on perceptions of helpful therapist actions, including insight, relationships and information. They suggested that insight may be enhanced in the context of a warm therapeutic relationship. Manne et al. (2010) found that the therapeutic bond predicted openness, which predicted realizations (including insight), which predicted perceptions of greater session progress. Similarly, Lunnen et al. (2008) found a strong relationship between satisfaction and perceived change. These findings suggest the need to incorporate feedback from clients exploring their perceptions of therapy and ensuring the relationship can facilitate insight for individuals. Botella et al. (2010) suggested that client's views were more relevant than therapists; Magill et al. (2010) suggested clients were more likely to report change than therapists; and Orford et al. (2009) found that therapists were prone to find more negative than positive factors following a session. Therefore client's views offer an alternate perspective worth considering alongside the therapist's perceptions of the therapy process.

Studies exploring technical differences were not consistent. Defife et al. (2008) found that individuals could detect technical processes and these were related to measures of outcome. However, Orford et al. (2009) found that although clients provided distinct

comments related to the therapy they had received, this did not impact on the outcome. Furthermore, they found that the most commonly coded category was non-specific; 'talking to the therapist'. Boswell et al. (2010) did not find a relationship between therapist training variables, intervention use and session outcome. Defife et al. (2008) and Boswell et al. (2010) found contradictory results when specific techniques were introduced within another therapeutic framework. When CBT was introduced within a psychodynamic framework, and clients could detect it, this was significantly correlated with positive changes in self report of wellbeing (Defife et al., 2008). The authors speculated that this positivity was related to the therapist being active, providing treatment information and including the client in topics to be discussed. However, Boswell et al. (2010) found that participants who received more common factor interventions on average rated sessions as less helpful when more CBT interventions were employed. Koocher, Norcross and Hill (2005) explain this latter finding by suggesting that the interpersonal nature of clients' difficulties is one reason why individuals seek therapy and certain directive CBT techniques may be more interfering with the therapeutic impact. Therefore it appears that current measures are not comprehensive enough to explain the complexities within this area of research.

3.3. Methodological Features of Studies of Progress Feedback

The sample sizes of individuals in these studies ranged from 74 - 2819. The total number of participants was 6532, and over half were female (62.4%). Ages of participants ranged between 18-71 years and ethnicity was generally stated as Caucasian (82.2%).

3.3.1. Study design.

The majority of studies were RCTs or quasi experimental designs with effect sizes reported (Reese, Norsworthy, Toland, & Sloane, 2010; Anker, Duncan & Sparks, 2009; Reese, Norsworthy & Rowlands, 2009a; Harmon et al., 2007; Reese et al., 2009b; Slade, Lambert, Harmon, Smart & Bailey, 2008), and one was a secondary analysis of an RCT (Halford et al., 2012). Randomization occurred either by condition (feedback (FB) or not), client or therapist, and was either informal (intake forms shuffled; Anker et al., 2009) or due to therapist's experience (student therapists were the blocking variable so as not to confuse them during training; Reese et al., 2009a; 2009b). Studies where therapists were working in both conditions may have had cross over effects resulting in them using strategies from the FB condition within the TAU condition (Harmon et al., 2007).

3.3.2. Sample sizes.

Large sample sizes were reported (Halford et al., 2012; Anker et al., 2009; Slade et al., 2008); however two studies with large samples compared an archival group with an experimental group, which could reduce reliability (Harmon et al., 2007; Slade et al., 2008). Reese et al. (2009b) reported insufficient power due to small sample sizes which resulted in a less robust analysis of the data. Attrition rates were high (Harmon et al., 2007; Slade et al., 2008) with 29.6% of individuals not returning for a second session in Anker et al. (2009); and over half not returning in Reese et al. (2009a).

3.3.3. Intervention length.

Intervention length was not usually stated as authors reported naturalistic treatment environments that were open ended in length; although Halford et al. (2012) reported an

average of 5.9 sessions delivered. The other studies reported the duration of data collection, for example 26 months (Anker et al., 2009; who also collected follow up data at 6 months). A recurring problem was the unequivocal amount of sessions individuals received in a treatment group and the difficulty of collecting data from individuals in the no FB group (Reese et al., 2009a; Slade et al., 2008) which limits the interpretation of the findings. Slade et al. (2008) also found a limitation in that clients' left therapy before they were able to implement one of their design features.

3.3.4. Methods and timing of obtaining feedback.

All of the studies used either the PCOMS (partners for change outcome management system; Miller & Duncan, 2004) which tracks outcome and therapeutic alliance; or the OQ-45 (Lambert et al. 2005), which measures client progress across subjective, interpersonal and social domains, as a method of gaining continuous feedback from clients at each therapy session. Both were reported to have good reliability and validity although Lambert et al. (1996) reported less empirical support for the PCOMS. However, Miller and Duncan (2004) found evidence of good construct validity (correlation coefficient of .59) between the OQ-45 and the ORS (part of the PCOMS). The same authors also reported that compliance rates for the PCOMS were 86% compared to 25% for the OQ-45. Other measures and design features were used alongside the FB conditions, such as clinical support tools (CST; Harmon et al., 2007; Slade et al., 2008); and the timing of feedback (Slade et al., 2008). Three studies explored the use of FB measures with couples, although measures had not yet been validated for this purpose (Halford et al., 2012; Reese et al., 2010; Anker et al., 2009). Limitations noted within most of the studies were that single self report measures were used (or data were

collected only on these) and the authors questioned whether the findings would be repeated with more comprehensive measures.

3.3.5. Fidelity to a manual and training.

Both the OQ-45 and the PCOMS had manuals however treatment fidelity was either informal (Slade et al., 2008) or implementation of the tools was left to the clinician's judgement and not monitored. Training of the FB tools, when stated, varied from one hour (Reese et al., 2009a) to 17 hours (Anker et al., 2009). Therapists included both qualified experienced professionals and students in training (including non-psychology professionals; Anker et al., 2009).

3.4. Results

All of the studies showed significant results which suggested that monitoring feedback from clients each session improved outcomes for clients on track and not on track (NOT) for therapy success. The areas of discrepancy or contradiction will be explored due to the consistent findings reported in the literature describing the benefits of progress feedback (e.g. Reese et al., 2010).

Individuals in the feedback conditions experienced treatment gains of more than double those in TAU and improvement occurred in fewer sessions (Reese et al., 2010; Harmon et al., 2007; Reese et al., 2009a). However, Harmon et al. (2007) found that clients 'NOT' attended more sessions than their no FB controls. Slade et al. (2008) found that NOT clients attended three less sessions on average with a week delay of FB rather than a two week delay, with similar treatment gains, therefore demonstrating greater efficiency and cost effectiveness. Therefore was keeping individuals in therapy longer beneficial to outcomes?

Did outcome depend on how therapists responded to the FB tools? Or was it due to the therapist's skill and experience in adapting to the clients' needs and working on the alliance?

Halford et al. (2012) reported that their study was "the first to show that deterioration or a lack of improvement in relationship adjustment during the first half of therapy predicted final outcome"; however, 31% of clients identified as NOT did improve and 29% on track did not (a miss rate of 54%). Christensen et al. (2010) have shown that those initially benefitting from therapy do relapse and vice versa, therefore how therapists intervene following the information received will have important clinical implications. Harmon et al. (2007) included anecdotal data of a therapist saying they did nothing with the feedback, expecting clients to deteriorate before they got better. The limitations in the studies reviewed were that treatment fidelity was not monitored and how therapists used the feedback tools was not clear.

Client's experiences of using the feedback tools was not investigated, although studies reported: a client opting out mid way as they did not want to complete the measures (Slade et al., 2007); and the high dropout rate after the first session was significant. Extrapolating trainees' experiences of providing the clinical feedback to their supervisor could offer some perspective on how clients may feel providing constant feedback. Reese et al. (2009b) found better client outcomes with feedback, but trainees did not experience a greater supervisory relationship or increased satisfaction. The authors suggested that trainees may have felt sensitive discussing a client not progressing as expected or the supervisor may have focussed more on the measures rather than the relationship, negatively affecting the trainee's perception of the relationship. Furthermore, Harmon et al. (2007) and Slade et al. (2008) found that feedback to clients led to no more gains than to therapist alone, indicating further research needed into client experiences of feedback.

3.5. Qualitative Studies

The sample sizes of individuals in these outcome studies ranged from 8-382. The total numbers of participants was 569, and a greater percentage were female (62.2%). Ages of participants ranged between 18-65 years and ethnicity was only reported once (Anker et al., 2011; 100% Caucasian).

3.5.1. Methodological issues.

The reader is advised to see Appendix E for a description of the quality appraisal and methodological features of the studies. Quality varied between authors being reflexive (e.g. Lambert, 2007), which Morrow (2005) identified as the researcher being aware of how their experiences and understandings of the world affect the research process (p.253), compared to researchers providing no information about their impact on the data (Sibitz, Amering, Gossler, Unger & Katschnig, 2007). A detailed procedure of the analysis was described in Lambert (2007); Anker et al. (2011); and Ward, Hogan, Stuart and Singleton (2008). Potential conflicts of interest also occurred where the facilitators of a group had designed it and were also evaluating it. Sibitz et al. (2007) involved psychiatrists leading a psycho-educational group, which patients felt weighed too heavily on a biological perspective. One finding was that the information led individuals to have less fear of medication and its side effects and so take more medication. Whitney, Easter, and Tchanturia (2008) reported largely positive feedback from patients with anorexia, however the nurses leading the group also cared for the patients who were aware that feedback would be used to evaluate the intervention. Therefore implications of giving feedback relating to ongoing care, and demand characteristics may have influenced individuals' accounts.

3.5.2. Results

Self agency and insight were themes commonly associated with perceived benefits and mechanisms of change occurring from therapy. Sibitz et al. (2007) found that participants recognised their own prejudiced beliefs and how their beliefs impacted on their behaviours; for example a participant said following the group she had to correct her belief that "the mentally ill stay in bed all day" (p. 911). Anker et al. (2011) found that clients' positive statements included the therapist having insight and also the therapist enabling the clients to view their problems from a different perspective. Nilsson et al. (2007) found that in CBT & PDT (psychodynamic therapy) satisfaction was linked to an awareness of one's own self agency and responsibility as a change item. Ward et al. (2008) found that positive experiences for clients came from the therapist displaying empathy, which was facilitative in leading to more realistic views and feeling understood. Whitney et al. (2008) also found that insight, for example, becoming aware of one's own beliefs, behaviours and ideals was a helpful step to further psychological work.

A certain level of skill was expected of the therapist, in their ability to come across as accepting and non-judgemental and yet to adhere to professional boundaries. Sibitz et al. (2007) found that negative statements amongst participants occurred when they felt group facilitators had not managed other group members appropriately and not stopped them dominating a discussion. Similarly clients were disappointed when it felt that the therapist allowed their partner to dominate the session and blamed the therapist for not being instrumental in guiding the session (Anker et al., 2011). The therapist and their skill was important to provide a safe space for constructive work, for example helping clients to self reflect and find ways of coping (Nilsson et al., 2007). They also found that satisfaction arose from feeling like the therapist understood them, was accepting and non-judgemental and

could adapt to their needs through their professionalism. Important client experiences consisted of the therapist being warm, empathetic and knowledgeable, including having a sense of where the client was at both emotionally and motivationally to tailor techniques to their needs (Whitney et al., 2008). When therapy ended abruptly or without agreement this led to dissatisfaction amongst participants (Lambert, 2007; Anker et al., 2011).

Dissatisfaction arose from: clients feeling confused or overloaded with information (Sibitz et al., 2007); uncared for and feeling like they were 'just a number'; that the therapist was 'just doing a job' or that they were 'waiting to move onto the next person' (Nilsson et al., 2007). Individuals who found it difficult to understand an exercise struggled to see the relevance of the information in an intervention to their current problems and wanted more guidance from their therapist in order to apply skills to real life situations (Whitney et al., 2008).

4. Discussion

The aim of this review was to systematically review and critique the research literature on the use of process feedback during and after a psychosocial intervention to explore how this had been used to evaluate the intervention. The review elicited three areas from within the literature, which were grouped according to the investigation of: therapeutic outcomes; progress feedback from clients to therapists; and clients' experiences of a therapeutic intervention.

The qualitative experiences of clients and the findings from the literature relating to 'therapeutic outcome' suggest that client satisfaction did not predict nor coincide with symptomatic change and that the association between satisfaction and treatment outcome was more complex (e.g. Botella et al., 2008; Nilsson et al., 2007). Studies exploring clients' perceptions of therapeutic techniques provided mixed findings on whether this impacted on outcomes (Defife et al., 2008; Orford et al. 2009). Interestingly the studies investigating technique identified both CBT (Defife et al., 2008) and supportive therapy (Ogrodniczuk et al., 2007) to involve an active therapist providing guidance and information, with differing outcomes as to whether individuals were satisfied with that or not. It would be of interest to explore what components of each technique work for different individuals and identify the similarities between therapies. The therapeutic alliance was investigated, suggesting a warm relationship and that the development of insight facilitated change (e.g.; Owen et al., 2010). Findings from the 'progress feedback' literature looked promising; however more research is required to investigate the mechanisms of change and how clients' experienced the process.

This review attempted to show what factors process feedback was dependent upon (recruitment methods, sample size, power and complexity of statistical analysis, interpretation of findings, attrition rates, measures used, therapist skill and experience) and how those

factors impacted on outcome and clinical decisions. For example, Slade et al. (2008) reported that because of the positive findings, the counselling centre they used no longer offers treatment to clients in the absence of therapist OQ-45 progress feedback. However, Reese et al. (2010) found that the research presented conflicting results as to whether client feedback was suitable for all clients. Halford et al. (2012) questioned whether feedback was used as a prompt for therapists to enhance a weak alliance or whether therapist factors, such as level of experience and utilising a range of therapeutic skills and techniques allowed one to adapt to meet the client's needs. Attempts to research experiences for clients who did not return to their second session and measures that actively explore dissatisfaction are required to ensure services do not make decisions based on the high face validity or positively skewed results of satisfaction and outcome measures (Lambert & Ogles, 2004). Also of importance is the question of when measures were taken and who saw the feedback, as this would likely have an impact on the reliability and honesty of the data. Clients within the progress feedback research knew that their therapists would see their feedback data at each session (e.g. Reese et al., 2009a). It was suggested that social desirability would be higher in measures assessing the therapeutic alliance as clients are more likely to withhold a negative reaction toward the therapist or session, rather than their own levels of distress (Farber, 2003). Ogrodniczuk et al. (2007) collected measures pre and post therapy and interpreted how clients within supportive therapy suppressed frustrated feelings towards the therapist during therapy, as the remit of therapy was not to discuss those transference feelings in the here and now. Consequently, dissatisfaction and outcome were related (post therapy when the relationship was no longer threatened), whereas they were not within interpretive therapy where space for difficult feelings was encouraged throughout. Lunnen et al. (2008) also collected data pre and post therapy and suggested lower reliability with retrospective data, drawing upon cognitive

dissonance theory to explain why ratings could be optimistic or negative depending on the individual's level of functioning at the time of measurement.

Correlations between satisfaction data and other outcome measures are mixed (Hill & Lambert, 2004). Satisfaction measures are often global, which assists researchers in measuring with a high degree of parsimony, but is likely to result in responses based on multiple factors. Single measures such as the ORS (outcome ratings as part of the PCOMS) were simple and quick to use (one minute each session) enhancing their use, but perhaps overlooking the complexity of clients' experiences (Anker et al., 2009). Further limits with quantitative measures were found in Botella et al. (2008) investigating the therapeutic alliance and weakening of the alliance. They found no association between relapse or a temporary weakened alliance with outcome. However, the way they defined their variable meant that it was a mathematical probability that an exaggerated high score of the alliance after the first session increased the likelihood of scoring it as lower after a future session (i.e. weakened).

Ogrodniczuk et al. (2007) explored an individual's quality of object relations whilst addressing dissatisfaction with therapy. They suggested that for certain patients (i.e. those with more primitive object relations) dissatisfaction with the therapist had a more adverse effect on potential benefits of therapy. Derlega et al. (2001) have suggested that the quality of someone's object relations plays a pivotal role in responses to difficulties in a relationship. They considered how perceived relational difficulties in therapy would be handled constructively or destructively dependent on an individuals' past. Owen et al. (2010) also looked at individual differences and addressed conformity to masculine norms whilst exploring helpful therapist actions. They found evidence supporting the complimentary hypothesis (Ogrodniczuk, 2006), which states that through gender socialization we learn certain skills and not others. Therefore therapists would attempt to teach individuals alternate

strategies for clients to internalise, such as learning to express emotions if they currently could not do that. The studies reviewed also highlighted the therapy modality would be influenced by the clinical need and setting. Magill et al. (2010) and Orford et al. (2009) both investigated users of alcohol and the impact of a 'significant other' (SO) in therapy. Important factors included the drinking habits and attitudes of the 'SO' and the therapist's ability to manage more people within a therapy session. These findings and those reported within the qualitative studies highlight the need for therapists to respond to individual differences and use their clinical skills to develop a strong relationship and then collaboratively decide whether the technique (such as working with transference feelings) or the therapy modality (such as interpretive) would be conducive to effective therapy. Bordin (1976) said that the therapeutic alliance is not healing in itself, but is an ingredient that makes possible acceptance and engagement in the therapeutic work.

An interesting consideration was that, particularly within the area of 'progress feedback' the same authors were involved in many of the reviewed articles. Lambert (2001) developed the outcome questionnaire (OQ-45) and was involved in four of the studies which all demonstrated findings in support of the benefits of the outcome measure. The evidence would suggest that the feedback tools are only above the level of chance at detecting clients who are deteriorating (Halford et al., 2012) and research into progress feedback should be investigated by independent researchers less involved in the development of the feedback tools.

The qualitative findings also suggested that clients appreciated therapists who could facilitate insight, challenge them appropriately and demonstrate professionalism and empathy to meet their needs. Further use of qualitative studies into clients' experiences of progress feedback would be recommended to explore the mechanisms of change and how clients feel

providing session by session feedback to the therapist.

4.1.Clinical Implications

The implications of this review suggest that government initiatives that are encouraging clinicians to routinely monitor and collect outcome data from clients (IAPT outcomes toolkit, 2008/2009) may be limited in their effectiveness of enhancing client experiences and therapeutic gains from therapy if symptomatic change or satisfaction is the only focus. The link between outcomes and subjective well being is a complicated relationship, with long term therapeutic gains not fully explored. It is worth considering how clients may experience providing constant feedback and how this would fit with the findings from the qualitative studies of clients 'feeling like a number' or that the therapist was 'just doing a job' (Nilsson et al., 2007). The studies reported within the review varied in terms of whether manuals were used, the orientation of the therapist and their level of experience and training with an intervention tool, which would likely impact on the findings of the results. Anker et al. (2009) found that there was significant variability in the effects of feedback across therapists, where less effective therapists benefitted more from feedback than their more successful colleagues. Research using process feedback has provided interesting findings on individuals' experiences and change within therapy and should continue to be researched from a wide range of methodological positions.

4.1.1. Limits of the review.

This review examined the key areas in the literature from 2007 that explored process feedback and how this has been used to evaluate psychosocial interventions. However, some limits of this review included the search terms used to find relevant articles, which may not

have been broad enough to retrieve all the relevant literature. To further explore process feedback interesting techniques such as interpretation and transference could be investigated, as well as literature from participatory and action research. In addition the inclusion criteria may have excluded papers from the review that demonstrated important findings. As there was a lack of a second researcher to examine the material and corroborate the findings this could also potentially call into question the internal validity of this review. Twenty four studies was a large number to critique and summarise within a word limited review, therefore another option could have been to narrow the search and critique in more depth fewer studies. However, as the review was interested in methods used to elicit process feedback it was considered that each of the three areas within the review offered something unique to the question.

A plausible conclusion from these findings therefore is that feedback from clients throughout therapy is useful in determining whether the psychological approach or technique is tolerable to them, whether they are feeling understood and if they are going at a pace that is acceptable to them. Dissatisfaction may be inevitable to some degree therefore a method of establishing whether this is facilitative to subjective well being or ego development, for example, is necessary.

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Section C

The psychodynamic approach to observing organisations: towards a psychosocial intervention

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By

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Doctorate in Clinical Psychology

Research Report Abstract

The research utilised a psychodynamic observation methodology involving a series of six psychodynamic ward observations of an acute inpatient ward. The project set out to explore the ward culture and learn about ward life and the current environment.

Process notes were written and then discussed within seven supervision group sessions to analyse the observation material. The data were transcribed and thematic analysis was conducted (Braun & Clarke, 2006). Academic supervision began after the initial themes were developed to analyse the findings at a latent level.

Five main themes were used to describe the ward culture from the observer's experience, which captured the dynamic processes and relationships between staff and patients. The behaviour of the staff and patients was explored in relation to unconscious defences and anxieties elicited on the ward, with reference to existing literature. Attachment and engagement issues were also considered. Recommendations were suggested and clinical implications discussed.

A follow on study is planned which involves presenting the current findings to the staff group in an attempt to validate the observation method.

1. Introduction

1.1.Background

1.1.1. Legislative changes.

Efficiency and cost effectiveness were emphasised during the end of the twentieth century which led to increased pressure on staff and organisations within public services (Obholzer & Zagier Roberts, 1994). There have been concerns about the poor quality of psychiatric inpatient care for the past fifteen years (Lelliott, Bennett, McGeorge & Turner, 2006), but in these austere times such an expensive, possibly ineffective aspect should be re-assessed (Sainsbury Centre for Mental Health, 1998; Healthcare commission, 2008). The recent coalition government changes have had a considerable impact on how the NHS is operated and financed, which has implications for staff and service users. Documents such as 'No health without mental health' (Department of Health [DH] 2011) describe how more responsibility is placed onto local services and communities to meet the needs of their community. However, this document also highlights the financial pressure services are under as it reports that by 2014 the NHS has to find £20 billion in savings, which will directly impact mental health services. Findings from Lord Darzi's report (DH, 2008) led to the creation of the NHS constitution (DH, 2009-2010), which is a document describing the legal obligations service providers and commissioners have in organising services according to the values and principles of the NHS. Key legislative documents highlighting the needs for individuals with mental health problems have focussed on the service users' experiences, the state of adult acute inpatient care and the importance of good mental health (DH, 2002; 2008; 2011; NICE publications, 2011). This undoubtedly has placed increasing pressure on staff and service managers within inpatient services to respond accordingly.

1.1.2. Acute inpatient care.

Unmet needs of both staff and service users have been indentified in psychiatric inpatient wards, which appear to coincide with the Government's emphasis on "community empowerment" (DH, 2011, p34; Healthcare commission, 2008; Holmes, 2002). Community teams, such as 'assertive outreach' and 'crisis resolution' have been established with the rationale that service users will engage with these teams and more readily accept treatment from them, reducing the need for inpatient settings (National Service Framework (NSF) for Mental Health, 1999). With resources being aimed towards community services over the past couple of decades inpatient services have encountered difficulties (Lelliott, 2006). The impact for those operating within an inpatient setting can be found in surveys that show that 82% of service users reported less than 15 minutes per day in face-to-face contact with staff (MIND, 2000, cited in Holmes, 2002). Other findings suggest that a weak therapeutic alliance and staff-patient difficulties can be a predictor of inpatient suicide and hostility and withdrawal from staff as a result of feeling de-skilled and unable to work, which can further lead to high levels of staff turnover and 'burnout' (Holmes, 2002; Kurtz & Turner, 2007). These factors may contribute to or be implicit in the finding from the Healthcare Commission that expenditure on acute wards remained the largest single element in mental health inpatient services, with regard to both estates and staffing (2008; DH, 2002). This not only has implications for those directly giving and receiving the care, but also for managers, commissioners and stakeholders of the service.

1.1.3. Ward culture.

Reports of service users and staff members' experiences of inpatient wards have illustrated a high level of criticism and dissatisfaction with current provision (DH, 2002). The ward environment has been considered important in creating a physical and therapeutic space important for psychological wellbeing for staff and patients. Kurtz (2005) reviewed studies of ward and team environment and found that violence increased when experienced staff were absent (James, 1990); and within benign environments, control may have inhibited therapeutic discovery (Caplan, 1993). Caldwell, Gill, Sclafani and Grandison (2006) found burnout to be highest in nurses in an MDT, which the authors attributed to negativity arising from a lack of interpersonal communication between staff and patients. Research on ward culture has utilised quantitative measures such as the Ward Atmosphere Scale, a 100 item rating scale (WAS; Moos & Houts, 1968a). Moos (1974) found that although staff and patients rated the environment as therapeutic, the staff thought they used minimal control compared to the patients who perceived them as controlling.

1.1.4. Qualitative approaches.

Limitations with quantitative measures are that the depth and range of what can be explored are confined to the constructs and potential limits of the measure. Hollway and Jefferson (2000) have produced qualitative data through interviewing individuals using the technique of 'free association'. The researchers argue that the way in which a subject presents in an interview situation is partly driven by the need to protect themselves from anxieties and psychic pain. This led them to coin the term the 'defended subject'. The researchers state that free association enables an individual's unconscious logic and emotional motivations to surface as opposed to rational conscious material. Hollway and Jefferson

(2000) suggest that a more traditional method, for example the standard interview technique, would not elicit this depth of information. Kurtz and Turner (2007) used qualitative approaches to explore contextual factors and areas of concern for staff working within a medium secure unit, and found that there were significant pressures from the organizational context. The Government emphasis on wanting staff in mental health services to be valued as much as other NHS staff indicates a cultural and organisational origin to the problems experienced (DH, 2011, p37).

1.2. The current Study in Context

1.2.1. An organizational unconscious.

Jacques (1953; cited in Hinshelwood & Skogstad, 2000) developed the idea of individuals using defences to cope with their unconscious anxieties and conflicts to the proposal of groups utilising this concept. He argued that a social system can support the individual's own psychological defences and that at an unconscious level individuals can use this system to defend themselves against their anxieties. 'Although it is the individuals who feel anxiety and operate defences, a defensiveness can also be locked into the social system' (p.4 Hinshelwood & Skogstad, 2000). It is the system then which operates as a whole that protects the individual from the anxieties and conflicts arising from the work in the organization.

1.2.2. Observation studies.

William Whyte (1943) began his sociological research in 1937, where he moved to the Italian American slum, employing a model of participant observation to learn about the people who lived there, their social structure, and their culture. His classic study, which has

since stemmed an interest in ethnographic studies, outlined how important it was to observe people in action. Whyte highlighted the complexities of being so intensely involved within research; developing trust with his participants, but recognizing where differences lay and not trying to change these.

The rationale for the observational method within psychodynamic theory attempts to gain insight into the culture's unconscious organisation and ethos. This relies on an 'observer' systematically studying a ward at specific arranged times to gather information and notice the emotional sequelae that this produces on oneself and others[3] (Hinshelwood & Skogstad, 2000). Hinshelwood (communication at a conference, 2010) described the origins of the observational method in child developmental studies (for example; Bion, 1962; & Bick, 1964) and in sociological studies (Goffman, 1961) that explored the nature of large mental hospitals' ward culture and organisation and the impact that this had on staff and patients. Goffman's (1961) observations of hospitals, prisons and monasteries led to the concept of the 'total institution' (Maysa & Pope, 1995). This describes individuals with a shared status living together isolated from society and conducting their life under a shared authority.

Menzies Lyth's (1960) pioneering observational study within a general teaching hospital in London fifty years ago aimed to elicit institutional change. The researchers were struck by the amount of distress and anxiety in the service and consequently the high drop-out rate of student nurses from their training. Other observations included high sickness rates and frequent changes in job roles in senior staff, compared to professionals at similar levels in other workplaces. Menzies Lyth (1960) described aspects and the nature of the anxiety present in the hospital, which at times arose from the conflicting and powerful feelings in staff; 'pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who

[3] 'Others' could refer to the members of the 'supervision group, discussed later, or the affect on those being observed .

arose these feelings; [and] envy of the care they receive' (p.440.) Researchers involved in other observation studies have described defensive techniques of staff in distancing themselves from their patients and 'touch and go' behaviours; for example frequently spending a limited amount of time with different patients (Donati, 1989; Chiesa, 1993). Other observational studies have explored: levels of violence fluctuating depending on the organisation of the ward (Katz & Kirkland, 1990); the prevalence of nurses acting in ways inconsistent with their task of nursing in rehabilitative care (Goodwin & Gore, 2000); the complexity and dynamic processes within an organisational system and how these impacted on the ward environment (Blacker, 2009); and, the existential challenges faced by residents and staff in a residential home for older people (Jones & Wright, 2008).

Stephen Frosh, a Clinical Psychologist who has an academic and research interest in psychodynamic ideas has raised a debate about how far one 'does' psychodynamic techniques outside of the clinic room. In a podcast *'Psychoanalysis beyond the Clinic'* he argues that 'transference' is based on a 'live encounter' and happens between two people in the here and now. Whilst he advocates the transferability and 'use' of psychoanalytical ideas beyond the clinic room his concerns centre around researchers, clinicians and theorists applying this method to literary texts, politics and ethics, as they miss the essence of what is created in a clinical room. Frosch has presented some interesting ideas around the challenges of psychoanalysis being applied more widely, including a reduced set of constraints on the application of it, which could be potentially harmful as one is predominantly using these techniques to talk about human subjects and behaviour. The benefits of the proposed study are that the observer will be present, allowing her subjective feelings to be stirred from the encounters with the participant groups, features which Frosch does advocate. Also, the observer will meet with a supervision group, allowing the material to be discussed in the

present and the settings of a ward in a hospital and a clinic room have more shared properties than a psychoanalytic study of a historical or political text, for example.

1.3.The Research Questions

One reason for using the chosen psychodynamic observation method was to investigate the added dimension of drawing upon the observer's subjective state to analyse the external observations. It is hypothesised that this will allow the observer to explore the difficulties and anxieties that staff must grapple with at an unconscious level because of the defensive structures within the culture.

The primary aims are:

1) To see what can be learnt from applying the psychodynamic observation method about a particular inpatient ward.

2) To process the information collated and analysed in order to present the interpretations to the participants involved in the project in some future consultation sessions with the staff members. The consultation sessions will form part of a follow on study intended to evaluate the psychodynamic observation method.

2. Method of Enquiry Adopted

2.1. Research Design

The psychodynamic observation method was selected to use in the current study (Hinshelwood & Skogstad, 2000).

2.2. Context of the Study

The current study took place within an acute psychiatric ward on a Hospital site located within the Midlands. The ward had 15 beds and was staffed by both qualified nurses and students in various stages of their training experience. Visitors to the ward included professionals within the multidisciplinary team, mental health advocates from outside organizations, including the voluntary sector, and family and friends of the patients.

2.3. Ethical Approval

The trainee gained ethical approval from the National Research Ethics Service (Appendix N) in January 2011.

2.4. Procedure

2.4.1. Observation procedure.

The method selected in the current study was an adaptation of the Hinshelwood and Skogstad's psychodynamic observation model (2000). General aims of the psychodynamic observations were for the observer[4] to attend to the general atmosphere of the ward and the social environment, and to attend to the nature of the emotional relationships between the different participant groups. The written process notes, taken immediately after the hourly

[4] Observer and researcher were the same person in the context of this study.

observation session, were a medium designed to capture the objective, subjective and emotional tone of the observer's interaction with the observational data. The process notes were subsequently discussed in the pre-arranged supervision meetings, which the observer also attended. During the Spring of 2011, six observations were carried out weekly, on the same day on the specified ward.

2.4.2. Supervision group procedure.

Staff supervision groups are required as part of the psychodynamic approach to analyse the observation material, within a psychodynamic framework (Hinshelwood & Skogstad, 2000). The aim of the supervision group, which consists of members with differing levels of clinical and psychoanalytic experience, is to help listen to and interpret the material brought to the session, helping the observer make sense of the data and understand the significance of what is brought for discussion.

Following an observation, within the same week, the supervision group met to discuss and analyse the data. The supervision group consisted of the observer, a group leader and two other mental health professionals with an interest in the area (Hinshelwood & Skogstad, 2000). In total, eight supervision meetings were held, one both prior to and after the observation period, each ninety minutes in duration. The final meeting, which considered the research data as a whole, was included in the analyses with the six observation meetings. Participants could share a range of emotions, thoughts and hypotheses generated from the material and/or each other, and were open to voicing any feelings they had towards the material, hence employing a psychodynamic approach to the supervision (Hinshelwood & Skogstad, 2000). The aim was to understand and make sense of what experiences they could. Each of those meetings were audio-recorded, transcribed and analysed by the observer. The

members of the supervision group either had previous experience working within the specified ward or were aware of the ward, but were not directly involved with the ward in any professional capacity during the project.

2.4.3. Supervisors.

The lead researcher had two supervisors. The field supervisor was involved from the beginning of the project and helped set up the supervision group. She was the group leader within the supervision meetings for the first four meetings, after which point she had to leave the meetings for unrelated reasons. The academic supervisor remained separate from the supervision meetings analyzing the observational material to ensure robustness to the procedure. She became involved during the researcher's independent analyses of the results and offered her advice and experience with qualitative research.

2.4.4. Consent and confidentiality.

Consent for the project to take place on the designated ward was sought from the Service Manager (via the Ward Manager) and Ward Manager. There were three separate groups of participants in the current study. The following sections describe the measures taken to protect each group within the research. The relevant invitation letters, participant information sheets, consent forms, and research poster can be found in the Appendices (Appendix G).

2.4.4.1. Patient participants.

All the patients who resided on the ward were regarded as potential participants. The project was discussed with the patients during a therapeutic community meeting. It was

agreed that staff would use their clinical judgement to advise the observer if they considered any person to be too unwell to take part in the observations. Any patient who read the observation poster and did not wish to take part could inform a staff member and /or the researcher and they would not be included in the observer's process notes. A summary sheet of the findings from the observations will be created to distribute to each patient that is interested in the outcome of the study.

2.4.4.2. Ward staff participants.

All staff that worked on the ward and were on shift at the time of the planned observations were regarded as potential participants. The researcher attended a staff meeting whereby the project was discussed and questions were answered in relation to the project details. Individuals were provided with contact details of the research team should they have had any questions or concerns. Ward staff were asked to provide individual consent if they agreed to participate in the study. Individuals were reminded that they could withdraw from the study at any time throughout the observations. Prior to each observation session the observer was available for an hour to meet with staff in case they had any questions or concerns of their own or on the patients' behalf.

The researcher discussed the 'feedback' element of the project with the staff. Further details of the consultation feedback sessions were agreed to be finalised after the results had been analysed and transformed. All staff that were involved in the observations were invited to attend the feedback sessions where the observation material and interpretations could be discussed at a future point.

2.4.4.3. Supervision group participants.

The field supervisor for this project was part of a group of clinicians/researchers who were either experienced in psychoanalytic theory and practice (or interested in it) and had experience as a core professional of inpatient clinical experience. The field supervisor sent an email to this local group asking whether anyone would be interested in joining a supervision group for an observational research project. Members who agreed to participate were asked to provide consent and informed of their rights to withdraw from the study at any time should they wish.

2.4.5. Choice of observer location.

An 'observation desk' was already established on the ward for staff members to carry out routine observations and monitor the locked doors, keep account of patients present and absent on the ward and record the arrival of visitors to the ward. The Ward Manager considered it appropriate for the observer to sit at the desk and carry out the observations for her research project in the same place.

2.4.6. Visitors to the ward.

Visitors were able to enter and leave the ward as they naturally would and the same opt out procedure was applicable. Visitors were able to clearly see the posters displayed around the ward and could ask the observer, who was identified by her name badge any questions that they had about the project. The observer's stance was to be as open as possible to questions, whilst trying to remain neutral and not get caught up in lengthy conversations whilst observing.

2.5. Measures

The observer approached the observations with an open attitude with the objective to remain curious with 'evenly suspended attention'; a Freudian concept (Sandler, 1976) to whatever may have come up within the observation period. In that sense no *a priori* criteria were set as the rationale behind the observations was to be curious and see what could be learnt about ward life, rather than approach the research with a quantified set of objectives or research questions in mind. The 'tools' used in the research were attending to the *transference* and *counter transference* (Heimann, 1950) of the observer (and how this was captured in the process notes) and the emotional responses to this from the members of the supervision group.

2.6. Transcribing

The researcher made herself familiar with the on-going debates within the qualitative sphere on transcribing methods, prior to transcribing the research data (e.g. Oliver, Serovich & Mason, 2005). The researcher transcribed her own audio recordings and used pseudonyms for all participants and all other individuals mentioned during the supervision sessions. Any names or places (such as wards) that could be identified were anonymised. The completed transcripts are attached as an addendum to the thesis.

2.7. Sources of Data

The current study included the use of the researcher's observation notes, the supervision group transcripts, and transcribed recordings of meetings with the researcher's academic supervisor during the analysis of the results. The researcher also kept a 'creative journal' that captured interesting ideas and thoughts she had throughout the research process.

2.8. Researcher's Position

The researchers' epistemological position is one of inter-subjectivity, inherent within the psychodynamic philosophy (see Appendix C).

2.9. Data Analysis

2.9.1. Decisions about the analysis.

Braun and Clarke (2006) outlined a number of decisions to be considered before commencing the analytic process (p.81). The researcher based her analysis on the following factors:

- The data were coded by 'meaning' units according to guidance in grounded theory research that recommended line by line coding when using thematic analysis (Charmaz, 2006);
- The entire data set was analysed to produce a rich thematic description of the important themes in relation to the concept of 'psychological mindedness' on the ward;
- Approaching the data from an inductive rather than theoretical position was sought, to allow the observer to learn from the observation experience, rather than attend to occurrences on the ward that fit within a pre-existing theory;
- The themes were to be identified at a semantic and latent level, depending on how much a topic was analysed or understood within the supervision discussion. Ideas or thoughts that needed further processing within academic supervision would be identified at a latent level.

2.9.2. Coding and thematic analysis.

A guide for conducting thematic analysis was constructed in Braun and Clarke's paper (2006) that the trainee followed. The trainee transcribed her own data, which is considered a major benefit in terms of familiarising oneself with the data (Riessman, 1993, cited in Braun & Clarke, 2006). The trainee then read the data before coding began to write down initial thoughts and ideas about each transcript. The next stage involved coding the data into 'meaning units', using a line by line guide (Charmaz, 2006) that captured interesting features of the data. 'First level' coding was denoted on the left hand column of each page of transcript describing the meaning unit at a descriptive level in the form of an 'action'. For example, there were two meaning units in the following sentence:

P: *'From what you say, um I felt that um, you didn't feel that comfortable/ and it sounds to me that you, you know the meet and greet wasn't there either/'*

The first meaning unit was coded as 'sensing discomfort' and the second meaning unit was coded as 'noticing a lack of introductions' (Observation 2, page 13, lines 14 & 15). The second stage was 'focussed' coding, which was denoted on the right hand column of the page, adding more interpretation to the initial coding and summarising the initial codes. As a guide the trainee attempted to summarise the initial codes (each page included roughly 24 lines of data and initial codes) to produce four focussed codes per page. Thematic analysis was selected to analyse the data and search for themes, due to the interpretive work having been conducted within the supervision group. (See Appendices H-K for a detailed account of the analysis procedure.)

After coding each transcript the trainee wrote down all the focussed codes onto a

separate piece of paper for each transcript (she treated each transcript separately until it came to searching for overarching themes at a later stage). She initially began by using headings on the page such as: 'trainee'; 'patient'; 'staff'; 'ward environment', to help her group the codes under certain categories. This enabled her to produce a list of theme names within each transcript. She then used cue cards, representing each theme name, to re-write each code onto the card, to clearly show where in the transcript evidence for each theme came from. She repeated this process for each transcript. In total fifty four themes across the entire data set were identified (see Appendix I for details). The researcher placed the theme names onto a large piece of paper to search for commonalities and patterns within the names. The researcher grouped the themes under the headings of eight overarching themes according to similarities between the themes (Appendix J). She then went back to her cue cards and re-wrote the codes under the revised sub and over arching theme titles (taking account of the whole data set now). She eventually used colour coding to try and save time as this became a lengthy process. The trainee spoke with her supervisor during these stages of the analysis to ensure that she knew why and how her original themes were changing and being redefined. Reviewing and redefining the themes is an inherent part of qualitative analysis (Braun & Clarke, 2006), which led to the final set of main themes and sub themes (Appendix K). Further latent analysis occurred during the academic supervision, which facilitated the development of the themes and sub themes.

2.9.3. Ensuring quality.

The researcher understood the importance of ensuring high quality standards were met throughout the research process and immersed herself in the data to ensure equal attention was given to the data set (Stiles, 1993). The researcher made use of her field and academic

supervisors and documented each meeting to ensure she acted on what was reflected upon. She was reflexive on her position as a trainee clinical psychologist, her role as an observer, and her own experiences and beliefs as an individual and how they impacted the research (see Appendix C; epistemological position). A creative journal was kept in order to track the development of ideas, and a detailed account of the method process was recorded to ensure that the results were grounded within the research findings and the process of meaning making captured (Lincoln & Guba, 1985). Starks and Trinidad (2007) describe the importance of respecting and listening to the participants' views without bias, which was why it was important to have a nurse representative within the supervision group discussions and have a reflective group that could add to the depth and range of discussions about the material presented.

3. Analysis of data

3.1 Introduction

The analysis is presented in this section according to five main themes and eighteen sub themes to provide an overall story of the findings (Braun & Clarke, 2006).

A diagram is presented (figure 1.) that illustrates how the main themes 'the problem with being on the ward', and 'a longing for engagement' were considered to be core anxieties underlying the other main themes. The other themes can be described as defensive ways of coping as a result. Each main theme is described and supported by sub themes and examples from the text and *in vivo* codes where appropriate. Examples from the text are taken either from the process notes ('PN'), which include direct observations and the observer's subjective experiences at the time; or the supervision group discussions ('SG'), originating from the presented material following an observation. Information referring to the observation number (e.g. Ob2) and page number (e.g. p34) of the text is also illustrated, for example: PN: Ob3, p22.

Each main theme was drawn from the observer's external (OE) and internal (OI) observational experiences, the discussions within the supervision group (SG) meetings, and more recently within the academic supervision (AS) sessions. A table is presented on p.56 that illustrates the most significant point of origin the material is drawn from for each sub theme in an attempt to capture the process of meaning making.

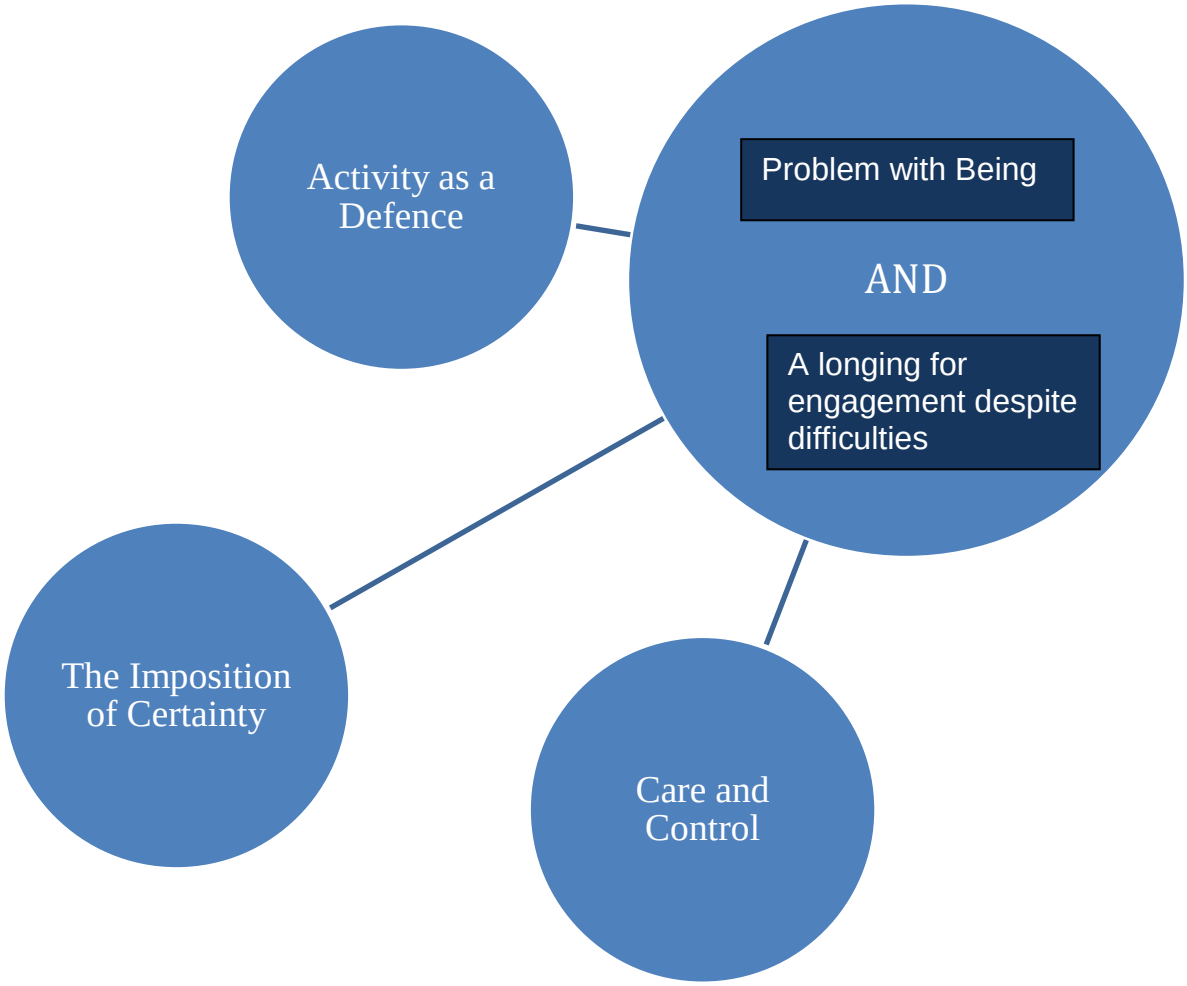

Figure 1. A relationship between the main themes

3.2. Findings

3.2.1. Main Theme: The Problem with 'Being' on the Ward

This theme describes how the ward environment itself was a strikingly difficult place to be for staff and patients. Throughout the observational material the sparsity of qualified staff was witnessed by the observer and discussed within the analytical group. Directly observing patients acting in particular ways and displaying certain behaviours led the supervision group and academic supervision to discuss the difficulty of really being known and feeling understood as individuals on the ward. Drawing upon the observer's subjective

experiences helped to identify certain feelings and thoughts related to the difficulty of being present and available to the patients, and the problems the patients and staff encountered as a result of staff's absence. During the academic supervision we considered a dilemma for the patients in particular with being on the ward: either you absent yourself through detachment of some sort or there was a need to force a presence in quite a false way.

3.2.1.1 Sub theme one: Presenting in challenging ways.

This sub theme highlighted the way patients appeared on the ward which was considered by the supervision group in terms of their need to receive attention. There were many occasions where patients would appear aggressive, angry, controlling, demanding, hysterical, argumentative, chaotic and disturbed. There was a sense of immediacy and urgency in the patient's behaviour that required staff to respond. This suggested a sense of risk and a need to prioritise those patients who would potentially escalate their behaviour if they were not given attention. This elicited discussions within the supervision group about patients' challenging behaviour being reinforced to get their needs met. What was also witnessed was the antithetical response from patients: where they did not present in challenging ways and were almost resigned to being overlooked or ignored.

PN: Ob1, p22: *'X* [patient] *came in shouting at her* [staff] *that he couldn't believe it took that long to open the door and that after 'x' weeks of working there she should know the patients she's working with.'*

3.2.1.2 Sub theme two: Coping through 'serene detachment'.

The observer found herself building a picture of the patients in different settings by the way they appeared; how they interacted with herself and others; and how they carried themselves when on the ward. Those factors along with the observer's response, such as feeling relaxed, calm, and her mind wandering to other more tranquil places, led her to describe the patients as strolling along a beach or being on a cruise ship for example. The supervision group and academic supervisor were struck by the descriptions, which stirred up images and ideas in them. It led to an idea of 'serene detachment' as a way of coping with not having your needs met at times, and feeling very isolated on a chaotic and unpredictable ward. It was considered functional for patients at times to cut off from an unbearable reality.

PN: Ob1, p22: '*She* [patient] *spoke kindly to the other patients, appeared to look away from those that were acting 'oddly' and made pleasant requests to the staff group'.*

SG: Ob1, p25: *'because of the description of her* [patient] *(laughs) thinking of her on a cruise ship and I thought* [SG member] *she sounds interesting. I wonder what that's um almost I don't know, cut off calm...'*

3.2.1.3.Sub theme three: Acting in a role.

Patients were directly observed being 'sarcastic and aggressive' to staff, but then 'co operative and helpful' to fellow patients. Members of staff, patients, visitors to the ward and the Manager were considered by the supervision group to be acting in certain roles and adhering to a role on many occasions throughout the observations. The observer identified with this when she found herself at times to feeling pulled out of her observational role; at

other times she only became aware of this when it was highlighted to her within the supervision group. Discussions about requiring a role and performing in a role occurred in the supervision group. Also, the functions and benefits of a role as well as the limitations and restrictions of acting (or being perceived) in a role were considered. The need for others to put you in a role was also highlighted. The observer subjectively noticed people changing from one role to another. For example:

PN: Ob1, p12: The observer experienced a patient as a 'needy child' on the ward, based on observations of her dependency and expectations of others; her tone of voice and her mannerisms. However, over the ensuing weeks of observations she was viewed by the observer and supervision group in a more 'able' role as she was preparing to go on leave from the ward, showing independence and making jokes with staff members (PN: Ob6, p18).

PN: Ob1, p11: *'He* [patient] *made a comment about how I had the 'designer frames' and seemed to fit that profession* [psychologist]*...He said that I had even got my expressions right, and when I asked him what this was he said the nodding and pulled the kind of 'hmm' expression...he said it was impressive as I was doing it already and still young'.*

The following example illustrates the supervision group discussing the previous material:

SG: Ob1, p32: *'oh you're young in the career,* [member of the group interpreting a patient talking to the observer] *your only young but you're in already and like that's it now kind of (x: yeah) um you've got that persona, and but like it's not, it doesn't represent anything real or it's not.'*

The above example referred to a patient stereotyping the observer. Academic supervision was used to think about the desperation of people really trying to work out who was who. It could be hypothesised that there was a vast amount of anxiety with patients feeling vulnerable and uncertain of who people were around them and how to interact with them.

Table.2 *Significant points of origin for material in the subthemes*

Sub theme	**Most Significant Point of origin** observer's external experience (OE) observer's internal experience (OI) supervision group discussions (SG) academic supervision sessions (AS)
3.2.1.1: Presenting in Challenging ways	**OE, SG**
3.2.1.2: Coping through 'serene detachment'	OI, SG
3.2.1.3: Acting in a Role	**OI, SG**
3.2.2.1: What is Meaningful Activity?	OE, AS
3.2.2.2: Being part of an action culture	**OE**
3.2.2.3: Retreating from the depressing reality of the ward	OI, SG, AS
3.2.3.1: Losing the capacity to empathise	**OE, OI**
3.2.3.2: Confusion in the moment	OI, SG
3.2.3.3: Constructing people two dimensionally	**OI, SG**
3.2.3.4: Forever waiting	OI, SG
3.2.4.1: An effort to engage	**OE, SG**
3.2.4.2: Engaging in a safe way – but does it meet the need?	OI, AS
3.2.4.3: Getting inside the mind of the other	**OI, SG**
3.2.4.4: Provocatively using words	OI, AS
3.2.4.5: Positive flipping to negative	**OE, SG**
3.2.5.1: Fear of 'getting it wrong'	OI, AS
3.2.5.2: Hard to get the balance between ensuring patients' safety and respecting their dignity	**OI, SG, AS**
3.2.5.3: Assuming patients can control their behaviour	OE, SG

3.2.2. Main Theme: Activity as a Defence

The observer and supervision group were struck by the common rhetoric of 'busyness' and the rushing around of student staff with the absence of qualified staff. However, paradoxically they also identified an emptiness and lifelessness to the quality of the interactions and the general feel of the ward environment. This encouraged many discussions around the apparent disparity of busyness and emptiness and the functions of busyness and high levels of activity. The observer recorded subjective experiences of a desire to be 'doing' more, such as having a book to read prior to the observations starting in order to look busy. The group also felt that at times the material presented by the observer felt full, but was lacking substance and they could not connect with the significance that the observer had intended to convey. When the observer appeared to record more of her emotional responses to the material on a 'less busy' day the group felt more engaged and moved by what was presented.

3.2.2.1.Sub theme one: What is meaningful activity?

The observer noticed an emphasis on the physical care of patients on the ward. The focus of much activity surrounded the necessary health care checks on patients, such as monitoring their blood levels, carrying out risk and service related issues, and observing patients for signs and symptoms of their mental health status. Staff spoke about there being plenty of activities for the patients to do. The observer noticed that patients had coloured in pictures of the Prince and his wife at the time of the Royal Wedding, which did not appear particularly age appropriate or stimulating. Furthermore, there were instances where it appeared that patients were seeking out some other form of contact from staff, such as being with a staff member, or talking to them about something meaningful.

PN: Ob3, p07: A patient was observed on one occasion making several attempts to converse with a member of staff about current affairs and the staff member responded repeatedly that she was too busy to have seen the news and consequently discuss the matter with her. The patient became very frustrated and then responded sarcastically when she overheard that staff member and a colleague joking about spelling a name wrong.

3.2.2.2.Sub theme two: Being part of an action culture

A *need* to be 'doing' was pervasive throughout the observations. The observer noticed that when she was pulled out of her 'observational role' it was 'to do' something for another; for example, pass a patient a cup, or a key, or look for a member of staff to operate the secured doors on the ward. The observer became aware that the ward was being evaluated from a range of perspectives: from patient satisfaction forms; to staff having to complete time monitoring forms. This led to discussions in the supervision group about working within a defensive culture of constantly having to 'cover yourselves' whilst also managing the risk on the ward. It was considered within the academic supervision that interactions with a patient, would often lead to an action. Furthermore, the wider rhetoric of busyness and job insecurity within the NHS was considered and the apparent criticism from others about not appearing busy:

PN: Ob2, p26: *'She* [visiting non ward member of staff] *made a comment that it must be nice us all sitting there compared to the chaos on her ward.'*

3.2.2.3 Sub theme three: Retreating from the depressing reality of the ward.

During the course of the observations the observer described the ward setting and the

interactions she observed between people. This impacted on the feelings of the members of the supervision group and how they perceived the emotional quality of the ward culture, noticeably what they felt the ward was lacking. Whilst acknowledging the realities for qualified staff being occupied within the staff room, an alternative consideration of their noticeable absence was to remove oneself from the ward environment. The observer experienced thoughts about moving the position from where she observed to seek out somewhere 'busier' after what she considered a 'quieter' preceding week, which was considered within the supervision group.

SG: Ob2, p23: *'It's funny how sometimes you focus on the things that don't seem to be there. I didn't feel like there was any warmth or um () you know there just didn't seem to be any humour, or you know those things that make a place more bearable to be in...'*

SG: Ob3, p21: *'...and then she rushed off* [a student nurse] *again, and I* [observer] *remember thinking ...it's ...lucky she's busy...whereas I'm stuck at the desk...If you're busy you can...go off if somebody catches you and you don't really want to talk to them.'*

3.2.3. Main Theme: The Imposition of Certainty

There was a tendency for staff (and patients) to construct people in certain ways, stereotyping people and making snapshot two – dimensional judgements of others. The drive to simplify and judge people was considered within the supervision group, and thought to occur when people were forced to make decisions in the moment. This could have been related to the pressures within the ward environment and the need to make quick decisions in an unpredictable environment. Times of confusion were directly observed and a need for

people to leave the intense situation. It was hypothesised in the supervision group that uncertainty was associated with high levels of anxiety and a need then to impose something certain and clear. Uncertainty also appeared to result in making patients wait for indefinite amounts of time whilst staff went searching for the information.

3.2.3.1 Sub theme one: Losing the capacity to empathise.

There were some dramatic incidences of ward and non ward members of staff not appearing to empathise with patients or understand them from a more holistic or psychological perspective. Crucially, the observer herself also experienced a difficulty in empathising with a member of staff and felt quite angry towards them 'in the moment' on the ward. This experience helped the supervision group to consider the dynamic function behind judging in the moment and requiring space and the perspectives of other people to shift one's thinking and understanding of an event:

PN, Ob2, p10: *'She* [non ward staff] *told me* [observer]... [*a*] *story of her telling a patient that they had to take control of their lives if they didn't want to come back here. She said "they lied to me when I asked whether they'd try hard when they left...they just keep coming back, so why should we try and help them if they are not going to help themselves?"'*

3.2.3.2 Sub theme two: Confusion in the moment.

There were occasions when the observer noticed moments where communication had broken down between people and something perceptively simple could not be understood. The paradox to this was when the observer subjectively experienced something of a disturbing and complicated nature that was not understood fully at the time and led her to feel

confused. This phenomenon was also experienced within the supervision group during consideration of the material where members initially felt confused and cut off from the content. The observer also noticed similar patterns throughout the process of analysing the data and meetings with her academic supervisor. The observer later thought about the function of having a separate space and time to gain some clarity.

PN, Ob2, p26: The observer responded incongruously to a patient on an occasion where he said something inappropriate to her and she laughed. On reflection she questioned responding in this way. Upon listening to the material members of the supervision group responded in the same way by laughing and it took a few moments to realise what was actually said and how disturbing the content was (SG, Ob2, p40).

SG: Ob2, p 17: *'...a lot of the questions were about certainty weren't they? ...Like "what are you? ...What's your role as a psychologist? ....It just feels like there's something about confusion and then within that maybe trying to make some sort of certainty...'*

3.2.3.3.Sub theme three: Constructing people two-dimensionally.

It appeared from what people said and how people related to one another on the ward that often individuals were known only at a more superficial level, rather than by anything more complex or with any depth to their personalities. Observations occurred of people being defined according to one characteristic. The observer could also draw on her subjective experiences of being interacted with at this level. It could be hypothesised that constructing people in this way was an attempt to know someone, yet ironically it appeared to create distance from actually knowing someone.

PN, Ob2, p09: A visiting member of staff spoke of patients collectively about being a certain way, with quite a judgemental and reductionist tone to what she was saying.

PN, Ob6, p01: A staff member spoke of mental health now being full of 'vagabonds and rapists'.

SG: Ob6, p35: *'...what it's making me* [member of supervision group] *think about is people being grouped together on one characteristic...as (X) would do being an inpatient...'these are the patients; this is the black nurse' or something...and that characteristic stands out to her more than his profession. And what that means to be reduced really to one aspect of you.'*

3.2.3.4.Sub theme four: Forever waiting

A patient being made to wait was a salient pattern throughout the observations. The observer often felt moved emotionally at these times and frustrated that patients were often left with no indication of when they would get an answer or be seen. It was hypothesised within the supervision group that making patients wait could be related to non-qualified members of staff (who were usually the only staff present on the ward) not feeling qualified or able to answer the questions. An alternative interpretation was competing demands for time or staff members requiring space and other colleagues to share the responsibility of answering the questions.

PN, Ob4, p24: *'She* [member of staff] *came back* [after a long wait] *and she explained that (X)* [nurse] *would have to send out a referral, then the OT would come and meet with*

him...[patient]. *He said o.k. She clarified he wouldn't be able to go* [to the group] *today. Again I felt an overwhelming sense of sadness.'*

3.2.4. Main Theme: A Longing for Engagement Despite Difficulties

A desire to engage with another was pervasive throughout the observations. Patients were often seen making connections with each other and supporting one another on the ward. It was considered within the supervision group and academic supervision to be more difficult for staff and patients to personally engage with each other. A number of incidences occurred where the observer was engaged in a conversation with a patient and these encounters were accompanied by powerful feelings that often left the observer feeling disturbed. Alternatively, the observer often felt overlooked, dismissed and unsupported following interactions with the staff group. This appeared to make attempts from both parties to engage unsuccessful: such as patients refusing to speak to a member of staff when it was offered and patient's queuing up at the staff door and being turned away.

3.2.4.1 Sub theme one: The effort to engage: 'Hold your breath, breathe out and do the robot dance and then pull yourself together again' (SG, Ob1. p 20).

A patient was observed acting bizarrely and dancing in one instance and then engaged the observer in a pleasant and relatively coherent conversation the next moment. The above quote was said within the supervision group after discussing this material, which appeared to capture the essence of what was discussed throughout the observations; there was a desire to engage, but there was a huge amount of effort that was required and a sense that one had to engage in a prescribed or expected fashion. '*Breathe out and dance'* captures the idea that patients then return to a state that is more comfortable and less conformist. The paradoxical

nature of patients' behaviour, however, made engaging quite frightening.

3.2.4.2 Sub theme two: Engaging in a safe way – but does it meet the need?

The question of how to engage with people seemed to be a difficulty for people on the ward. The observer was struck on a number of occasions by 'exchanges' that occurred between people on the ward, for example, sweets, newspapers, and money. Over time, through discussions with the observer's academic supervisor, the exchanges were considered as expressions of a longing to engage with people, made in the form of material exchanges that perhaps substituted for something more emotional.

PN, Ob5, p.5/6: *'(X)* [patient] *had told me* [observer]*...that he had waited for ages to see a Doctor as he wanted to know if he could go out yet…eventually one of the… doctors…*[took] *him into a room for a chat. Interestingly, when he re-emerged…(X)* [nurse] *asked if there was still a cd player on the ward…I* [observer] *thought that it felt like some sort of bargaining or negotiation; "we can't give you what you want but here's something to pacify you in the meantime".'*

3.2.4.3.Sub theme three: Getting inside the mind of the other.

The observer drew on her subjective experiences from the observations to identify with staff and patients. She felt sad and frustrated for the patients when they had to wait, and when they appeared helpless and powerless; but she also felt despairing and persecuted when identifying with the staff group when patients were being challenging, demanding and aggressive and considering the lack of support in the system they were working in. One of the most powerful experiences felt by the observer was when it felt like patients were 'getting

into' her mind and this left her feeling at times shamed, exposed, disturbed and vulnerable. The quote below was taken from a patient talking with the observer that elicited a sense of the disturbing quality behind the words spoken and how it left the observer feeling shocked, uncomfortable and confused.

PN, Ob2, p26: *'He* [patient] *said he should warn me that he was Catholic. I* [observer] *said o.k. My brain was racing thinking if he was referring to anything sexual at all. He then also asked if he could cuddle me. I said "no, I can't do that". He then said "what about sex?" I said no. He then said something quite crude that made me feel quite uncomfortable writing it down. He said "just a couple of pumps it won't hurt much"...He then walked away.*

3.2.4.4.Sub theme four: Provocatively using words.

The power of words was noted and how words could be used to elicit a response from another person. Observations of staff walking away from patients and staff inhibiting conversations with patients were common. Patients speaking provocatively appeared to have the effect of not wanting to hear the words spoken. The supervision group discussed the danger in staff members potentially saying the wrong thing to patients, where this could be held against you, within an environment that is potentially threatening and within a culture of blame. The observer recognised this herself when she tried to avoid continuing conversations with patients when they were suggesting negative aspects of the ward life, or when she was relieved at not being drawn into a difficult conversation with a patient. The observer and her academic supervisor recognised that she was identifying with the staff group by this point in the observations and was anticipating the feedback to the staff group. The observer thought with her academic supervisor about the anxiety of knowing what to do as a member of staff

when you hear the words spoken.

PN, Ob5, p3: *He* [patient] *said something that stayed with me as it felt quite provocative: that "being injected through the bum felt like being chemically raped".*

SG, Ob4, p.16: *'So yeah…if you stick to…as a nurse saying what you need to do check the weight, the things that you can almost factually kind of check…and if there's less room for…maybe talking or saying something that could trigger a response, then your almost protecting yourself.'*

3.2.4.5 Sub theme five: Positive flipping to negative.

This theme refers to a suspicion of what people said and did on the ward and the assumption that something positive would be used negatively. The observer detected a level of hostility and suspicion from nurses and this may have affected their motivation to engage with this project due to a fear of how the outcome may affect them. The supervision group also thought about other evaluation projects being 'sold' as positive to staff members, with an underlying hidden agenda. The supervision group discussed how it felt that there was a fear of forming an attachment with patients as subsequently saying 'no' would be received as even more rejecting than from a nurse who had not engaged with them initially. This appeared to signify the brittleness of human relationships on the ward and how anxiety provoking it could be to engage with people if there's a sense things will always turn.

The quote below refers to a patient in a 'manic' phase using a staff photograph on the wall to point out staff members who she perceived to be helpful or unhelpful. She was using this to communicate with staff members, patient advocates and other visitors to the ward:

SG, Ob5, p26: *I* [member of group] *found it really interesting what you said about the photograph...because obviously photographs are put up to be helpful aren't they...but she* [patient] *was using it in a very negative way...and I guess she would be able to target people by looking at the photographs...'*

3.2.5 Main Theme: Care and Control

Observations of staff avoiding disclosing personal information to patients, and visiting members of staff talking about psychologists being able to suss out their 'weaknesses' elicited ideas in the supervision group that staff could give too much of themselves away or feel exposed by getting too close to people. The observer could identify with her own feelings of 'being sussed out' by patients, and 'not getting it right'. This led to the idea within academic supervision that a way of staff protecting themselves was to care in a very clear and controlled way. It was hypothesised that the staff's task of caring for patients was anxiety provoking, which led them to focus on the patient's physical health care.

3.2.5.1 Sub theme one: Fear of 'getting it wrong'.

The observations of staff avoiding being on the ward led the supervision group to consider the staff group as being very anxious about engaging with patients. Staff members questioned how the observer would judge what was 'right' or wrong' in her observations on the ward. There were occasions when the observer strongly identified with the staff group in a sense of 'nothing being good enough' following their interaction with a demanding and critical patient. There were conversations in the supervision group about staff not being able to trust in their own observations in deciding whether a patient was 'mad' or not, and the idea

that experience was required. The observer carried feelings of 'not getting it right' throughout the project, which were explored with her academic supervisor. The supervision group considered the possibility that one staff member who always appeared to be ignoring patients by reading a newspaper, was actually quite anxious about engaging with patients. The following quote refers to this staff member pleading for a patient's co-operation:

SG, Ob5, p.23: *'...as soon as you said about the 'please' thing I completely re-formulated him altogether. I just thought this guy is so anxious...he's frightened of people talking to him...he's as scared as everyone else there really.'*

The following example illustrates the potential danger and consequences of engaging with a patient at a deeper level, and how this could leave staff feeling like they had not managed the situation correctly:

SG, Ob5, p34: There was a sense that engaging and potentially unravelling one person would unravel everyone else.

3.2.5.2.Sub theme two: Hard to get the balance between ensuring patients' safety and respecting their dignity.

Patients spoke about the humiliating aspects of being on the ward and the observer noticed the dilemma in observing a patient in a 'manic' phase and fantasising about the shame the patient would feel as a result of being closely observed. There were discussions in the supervision group about how one ensures that patients still have some control over their lives and decisions and take some responsibility whilst on the ward; but how staff facilitate this

considering patients' paradoxical nature and unpredictable presentations. Discussions with the academic supervisor led to the idea that staff taking on responsibility for patients and doing things for them enabled them to show they cared. However, this occasionally resulted in staff doing a lot for patients that they were capable of doing themselves.

The quote below refers to a patient anxiously requesting to wash her own clothes and not use the industrial powder, however the staff member tries to reassure her that they would watch that her clothes would not be stolen and that industrial powder was her only option if she could not provide an alternative.

SG, OB3, p.15: *'I* [member of group] *felt there was a bit of a theme regarding empowerment, and how on the one hand we try to empower them* [patients] *and on the other hand we kind of restrict their liberties...the washing powder struck me...putting your washing in somebody else's...machine...you could have your clothes stolen...I'm so allergic to...industrial washing powder...we don't...think of individual needs, and it's about security as well.'*

3.2.5.3.Sub theme three: Assuming patients can control their behaviour.

There were occasions where staff members spoke about patients needing to help themselves and not repeat their mistakes. Staff and family members struggled to empathise that patients may not have the skills, knowledge, insight, internal resources, support, or past experiences to enable them to make positive changes successfully. Family members also spoke about controlling individuals through disciplinarian and controlling acts, for example, the observer heard a family member say to a member of staff that their family member would

not dare run off from them if they took them out on leave because 'they would go mad if they did'. Discussions in the supervision group relating to the observational material about patients saying one thing but behaving in seemingly paradoxical ways led to the group members bringing in their own examples of similar experiences from an inpatient setting. This elicited conversations about patients behaving in conscious and unconscious ways that were difficult for themselves and staff members to make sense of. For example:

SG, Ob6, p27: *'I think people still think people then have choices or manipulate things...there's a lot of that unconscious stuff going on but what do people understand of that? And how do they kind of respond when somebody is acting in opposing or conflicting ways...'*

4. Discussion

4.1 *Summary of the Research Project*

The current study aimed to explore the ward environment of an acute inpatient ward replicating recent studies utilising a psychodynamic observational methodology (Katz & Kirkland, 1990; Goodwin & Gore, 2000; Blacker, 2009; unpublished thesis; Jones & Wright, 2008). In line with Government recommendations on improving the therapeutic atmosphere of inpatient wards (Healthcare commission; HCC, 2008) and moving away from the dominant medical model (Sainsbury Centre for Mental Health; SCMH, 1998), a formulation of 'psychological mindedness' was held in mind when analysing the data. Five main themes were developed that explored the difficulties for staff, patients and the observer with being on the ward and the organisational systems in place that made the task of engaging and attaching to one another problematic. Jacques (1953) described a social defence system as one that allowed individuals to avoid certain anxieties and conflicts that were elicited through their work (in Hinshelwood & Skogstad, 2000). The concept of the social defence system can be used to think of organisational systems as ways of defending against a 'problem of being', which are in some ways counter-productive.

4.2 Extending Previous Findings within the Literature

4.2.1 Main theme one: problem with being on the ward.

Patients were observed presenting in challenging and chaotic ways, displaying levels of verbal aggression and high emotion, consistent with previous findings in the literature (Bowers et al., 2009; Lelliott et al., 2006). Holmes (2002) argued for attention to be directed toward inpatient wards due to the most ill patients being there at any one time. Foster,

Bowers and Nijman (2007) found that 60% of 'incidents' in one hospital in London involved verbal aggression, with the most frequent outcome for the victim feeling threatened (59% of incidents). There were references during the observations to 'incidences' of physical violence between patients and a patient who had attempted suicide with a student nurse being hit in the process. However, patients were also observed in a detached and calm manner, a finding which has been less prevalent within the literature. Patients who were detached may have been benefiting from perceiving the ward as a sanctuary (Haglund & von Essen, 2005). Or they may have been detached from their reality as a defensive manoeuvre due to the unpleasantness of the ward environment. Donati (1989) described defensive manoeuvres by staff as a response to an intense anxiety. The supervision group drew upon the trainee's counter-transference responses developing the sub theme 'coping through serene detachment', which highlighted patients' ability to distance themselves psychologically from their immediate environment. Gjerden and Moen (2001) found that patients were sensitive to changes in the ward environment and that patients who appeared to function better received less attention than those who appeared most unwell. It was difficult in the current study to identify whether staff responded to patients who appeared less demanding, which raised questions about the long term prognosis for those patients. Or, whether detachment was a way patients coped when their needs could not be met within their environment.

4.2.2 Main theme two: activity as a defence.

Busyness was considered as part of an organisational pressure on staff, which restricted them to the office but also allowed staff not to spend long on the ward with patients. This left inexperienced student nurses, health care assistants, bank and non-ward staff to occupy the ward, a situation which has been associated with increased levels of violence by

patients (James, 1990; Kurtz, 2005; Department of Health; DH, 2002; Holmes, 2002; Kurtz & Turner, 2007). James (1990) found an increase in violent incidents when agency staff members were working on a psychiatric ward and experienced staff members were absent. Healthcare professionals have been found to protect themselves by avoiding patients who cause them discomfort (Jones, 2008). Donati (1989) described distancing of staff and patients in what was described as 'touch and go behaviours', which maintained 'depersonalised relationships' on a chronic long stay psychiatric ward (p.43). One-to-one contact, with staff patients know, is thought to contribute to the atmosphere of the ward culture and is considered to be meaningful to staff and patients' wellbeing (DH, 2002; The Kings' Fund Charitable Foundation, 2008). However, the emptiness experienced in the current study led to the sub theme 'retreating from the depressing reality of the ward', a finding Chiesa (1993) elaborates. Chiesa (1993) reported a lifeless atmosphere when observing an acute admission ward, and suggested that the busyness of staff represented a 'manic reaction in order to bypass anxieties about fragmentation, worthlessness and hopelessness' (p.65). Staff in the current study could have been grappling with similar issues, such as feeling hopeless about how to help people with such complex difficulties, using the busyness to distract them from such feelings and make them feel like they were '*doing*' something helpful.

4.2.3 Main theme three: imposition of certainty.

Members of staff were observed developing a view of patients as having a lack of willpower and self control. Empathic understanding of patients' difficulties was rare, consistent with other findings. Olofsson and Jacobsson (2001) using a qualitative approach found that patients involuntarily hospitalised led to feelings of not being respected as a human

being and feeling inferior. Jones (2008) described how staff may lose the capacity to empathise when they experience preoccupying feelings of guilt, shame and failure. Individuals cope with these unwanted feelings through the defence of externalisation, which places feelings of blame and denigration onto others, likely to be the patients (Jones, 2008). Within the current study a lack of empathy was understood in terms of confusion and helplessness on the ward, due to staff member's lack of knowledge about psychological aspects of mental health, resulting in the staff feeling out of control. Stereotyping was an attempt to reduce the ambiguity and make the situation more predictable. Within the current study further examples of patients waiting were formulated as staff with less authority having to find qualified staff to take responsibility for decisions made on patients' behalf. These factors reflected the organisational problems of qualified staff being duty bound in the office and non ward staff (with potentially minimal training on mental health) having to respond in the moment without further support or time to think about their responses.

4.2.4 Main theme four: a longing for engagement despite difficulties.

Staff attempted to communicate with patients by initiating brief conversations as they were passing by, or exchanging food when offered, suggesting a motivation to engage. According to the literature, patients and staff benefit from training that specifically targets their reciprocal interactions (Honsany, Wellman & Lowe, 2007); and psychosocial interventions benefit both groups, leading to patients feeling better about themselves (York, 2007). However, without any evidence of such interventions on the ward and the aforementioned lack of interpersonal contact, patients were assumed to have unmet needs. Furthermore, the disturbing nature of patients' difficulties and their unpredictability resulted

in feelings of increased anxiety, incompetence and a fear of being exposed in the observer. The observer also suspected that when she felt exposed by the patients and felt they were 'getting inside her mind' this reflected an unconscious warning from them that she should not try and get inside their minds: this also could be an unconscious message they give to staff. These feelings were hypothesised to be an unacknowledged unconscious communication from patients that resulted in staff distancing themselves from patients. It was hypothesised that offering a material exchange to patients was recognition of a patients' unmet needs and staff's compensatory efforts to alleviate some of their distress. This idea would support Chiesa's (1993) description of staff feeling worthless and hopeless and offers an explanation of how staff responded to such distressing feelings. Caldwell et al. (2006) found burnout to be highest in nurses in an MDT, which the authors attributed to negativity arising from a lack of interpersonal communication between staff and patients. This suggests that nurses want this level of communication but perhaps do not feel supported to interact with the patients and their level of disturbance.

4.2.5 Main theme five: care and control.

It was felt that staff tried to show a level of care towards the patients by dutifully attending to their physical needs and taking responsibility for them when it was forced upon them. However, there were also occurrences where patients were not given a choice over their care or personal needs. This fits with studies describing staff as having a "controlling" or "hard" attitude towards patients (SCMH, 2006). Studies have shown that staff and patients differ on their perceptions of the level of control exerted by staff, with patients perceiving this to be higher than staff (Rossberg, Melle, Opjordsmoen, & Friis 2006; Moos, 1974). Within the analysis this aspect of care and control was considered in terms of staff responding to a

cultural attitude of prioritising the medical model and attending to physical needs over psychological needs (Parkin, unpublished thesis, 2011). Furthermore, patients' unpredictability may lead staff to operate from a defensive position and become fearful of what impact a patient's emotional disclosure could have on them and the other patients. This fits with findings in the literature that a tolerance for expressions of feelings was low and that patients are more likely to perceive these wards as controlled (Caplan, 1993; Moos, 1974). Possible reasons why staff may prefer to operate from a medical model are due to staff not feeling confident engaging patients personally (Richards et al., 2005) and that staff have not been trained in facilitating therapeutic environments (HCC, 2008). Meegens and Van Meijel (2006) found that staff emotionally withdrew from patients; and Fagin (2001) found that staff were idealised and disliked by patients. Therefore these factors, accompanied by the powerful feelings already described within the culture, suggest that staff try to resume some control in an unpredictable environment by drawing upon their medical training. This opinion would favour the findings in the literature that nurses are anxious (Westhead, Cobb, Boath & Bradley, 2003), rather than unmotivated to deliver therapeutic interventions (Grandison, Pharwaha, Jefford & Dratcu, 2009).

4.3. How the Formulation Developed

The method made use of the subjective experience of the observer in order to try to make sense of unconscious communication by the ward staff and patients. The method allowed the observer to experience the unconscious anxiety staff may be defending against and so empathise with them rather than just hypothesize about their feelings. The observer's feelings, including areas of uncertainty were made sense of in supervisory settings removed by distance and time from the original observation, and the analysis tracked which themes

were developed in what setting. For example, the academic supervisor worked with the trainee to understand the significance behind the observer's sense of there being something important about the 'exchanges' she observed, which led to the creation of a sub theme *'engaging in a safe way but does it meet the need'*. The possibility was considered that material imbued with strong feelings and ideas that had taken a longer and more in-depth analysis to really understand were unconscious issues the staff group were grappling with on the ward.

Findings from the literature on post traumatic stress disorder (PTSD) offer an interesting analogy. Harman and Lee (2009) suggest that emotions, and in particular shame, are prevalent features of PTSD. Theories suggest that traumatic experiences are processed in a way that leads to a state of current threat. 'Hotspots' are distressing memories that have been suppressed from the individual's consciousness and often contain the individual's most feared or shaming thoughts, feelings or memories that are targeted within therapy. Generalising those concepts to the current study it could be suggested that the feelings of shame, disturbance and exposure the observer experienced belonged to the staff and patients, but were inaccessible to them as they did not have a safe forum to address these issues. Instead the staff group avoided a sense of danger, such as the ward, and did not have an opportunity to understand their feelings. It is hypothesized that the staff are also picking up on the unacknowledged and inaccessible feelings of the patients. Considering the mental health difficulties associated with patients typical of an inpatient setting (Holmes, 2002) it could be argued that most have experienced some or many traumas, which may be repeated on an inpatient ward.

Menzies Lyth (1960) in a seminal observational study emphasised the likeness of the situations the nurse's face, in caring for the sick and mentally unwell, to the unconscious

phantasy situations that exist at a primitive level in every individual's mind. She argues that the specific features of a nurses' work or 'task' (for example, close contact to the sick, chronically ill or disfigured) conjure up these early unconscious situations and emotions[5]. Furthermore, based on the nurse's own idiosyncratic early childhood experiences and inner phantasy world (including objects, parts of themselves and other people) their anxieties may be heightened by the unconscious associations with the patients' and relatives' distress in the present (p.441). This makes their task of caring particularly complicated and potentially disturbing. Jacques (1953; cited in Hinshelwood & Skogstad, 2000) developed the idea of individuals using defences to cope with their unconscious anxieties and conflicts to the proposal of groups utilising this concept. He argues that a social system can support the individual's own psychological defences and that at an unconscious level individuals can use this system to defend themselves against their anxieties. 'Although it is the individuals who feel anxiety and operate defences, a defensiveness can also be locked into the social system' (p.4 Hinshelwood & Skogstad, 2000). It is the system then which operates as a whole that protects the individual from the anxieties and conflicts arising from the work in the organization. These ideas appeared relevant to the current findings.

Miller has described work with organizations, including work within residential settings where the individuals felt that they were 'suffering from a restrictive regime that failed to acknowledge their needs and capabilities as adult human beings' (p.29). He carried out an action research project and worked intensely with the individuals in the setting to create something more akin to a 'therapeutic community' where a culture evolved that allowed the residents to take more control over their own lives. Interestingly, Miller and Gwynne (1972) offended some readers with their language in their report of the study;

[5] For a description of 'infantile psychic life' see Menzies Lyth (1959); the work of Freud; and Klein (1952b; 1959)

although their aim was to highlight the hypocrisy of society's ambivalence towards its physically disabled members, and the empty rhetoric that portrayed the help available as something much more idealistic, yet was lacking (p.30). It is hoped that the current research can also help bridge a gap between the life of individuals on an acute inpatient ward and societal perspectives, and bring some of the unconscious issues for the staff members and managers to an open arena where they can be thought about safely.

4.4. Concluding Comments

Due to the re-organisation of mental health teams and the introduction of community services the quality of the population on acute inpatient wards has changed (Chiesa,1993). This has been suggested to have implications on staff morale as staff see fewer positive outcomes, which have been associated with staff wellbeing (Hummelnoll & Severinsonn, 2001). However, a systemic problem may be inherent in associating positive outcome with symptom reduction and not meeting the needs of those who 'appear' to be functioning well or creating a controlled atmosphere that stifles emotional exploration (Moos, 1974). A review of the quality and effectiveness of inpatient care found that many patient needs were not being met as services focused on their symptoms, resulting in 50% of individuals readmitted within the year (Sainsbury Centre for Mental Health, 1998). It would therefore be interesting to further explore the trajectory of those patients considered to be functioning well or who present as calm on the wards to address the question of whether their needs were met on the wards.

4.5. Clinical Implications

This study highlights the unmet needs of staff and patients on an inpatient ward and the support required for staff in order to carry out their task of caring for patients in a sustained and rehabilitative way (Miles, 1999). At present the organisation is not facilitating staff to contain and attend to individuals' complex and dynamic psychological needs as well as their physical needs. Whilst Government policies highlight the need for inpatient service provisions to improve and mental health staff to be valued (DH, 2011), there is limited information giving detail as to how this will be implemented. Furthermore, due to recent changes in international recommendations restricting the use of seclusion, services reliant on these measures to contain individuals will have to devise some more therapeutic system for managing distressed and challenging patients (Sailas & Wahlbeck, 2005).

Appropriate support mechanisms for staff such as supervision utilising psychodynamic concepts to formulate patients' difficulties (Fagin, 2001); reflective practice that can provide containment; a space to verbalise dissatisfaction (Flood et al., 2006; Brennan, Flood & Bowers, 2006); and training on psychological models of mental health (Ferraz & Wellman, 2009) would be recommended. These measures would reduce the need for defensive ways of coping to develop. For patients, therapeutic support, appropriate activities on the ward and being involved in their care would be advised (York, 2007). Lynch, Ryan and Plant (2005) suggested that meeting the needs of one group is likely to impact positively on the other.

Difficulties lie ahead in the covert assumption within Government policies that admission to hospitals should be avoided through effective joined up community care (DH, 2011). Organisational shifts from viewing admission to inpatient wards as representing a failure of the individual or service needs to take account the 'potentially valuable therapeutic

option' to be gained from developing quality inpatient services (Holloway, 2006).

4.5. Limitations of the Study

There are a number of limitations with the current study that are worth highlighting. The psychodynamic observation methodology draws heavily upon the researchers inter-subjective responses to the clinical setting and people present or absent. Whilst this is a strength of the model, it is also a criticism of the model as it could be argued that the findings are based largely on the researchers beliefs. Due to unforeseen circumstances the lead member of the supervision group had to leave part way through the meetings, which also altered the dynamics of the group meetings. Also, due to the financial climate and current state of insecurity within the NHS it has not yet been possible to release the staff group for the pre-planned consultation sessions. Not only would this opportunity offer some triangulation and a way of evaluating the model, but it is also important ethically to share the findings of the study with the staff group at an appropriate time. Ongoing business meetings have taken place at a Managerial level and the plan is to deliver the consultation sessions within the autumn period. Further research in this area is required to evaluate the model and investigate whether it can be of help in terms of bringing unconscious defensive practice to light within NHS clinical settings.

4.6. Future Research

The present study has replicated recent innovative designs to explore ward culture using a qualitative method due to the limits of quantitative measures (Tilbury, unpublished literature review, 2012). It extends the literature by adding the feedback element to the design to facilitate a medium for staff to be supported to hear the results and contribute to the

research process. The development of the follow on study has already passed ethics and is awaiting an appropriate time that the ward can facilitate this. Ideas for the future include inviting staff members to take part in an observational study as an experiential learning opportunity and investigate any changes within their attitudes following the process.

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Section D

Critical Appraisal

Submitted April 2012

By

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To The University of Leicester, School of Psychology, Clinical Section,

In partial fulfillment of the degree of,

Doctorate in Clinical Psychology

1. Critical Appraisal

1.2.Selection of Research Topic

1.2.1. Choosing to conduct research on an acute inpatient ward.

Throughout my placement experiences as a clinical psychologist I gained an interest in the different services within the care pathway model available to people suffering with mental health difficulties. I had worked as an assistant psychologist within an early intervention team where the focus was on community support and recovery, then gained experience on a child placement; where occasionally children were forced to stay within an adolescent psychiatric unit, and then a rehabilitation and recovery service where adults were commonly in and out of psychiatric hospitals due to the complex nature and longevity of their difficulties. Thus I had fantasies about what the culture of an acute inpatient ward would be like but had no experiential knowledge to draw upon. These were more negatively held beliefs about the secondary handicaps people gained from residing on a psychiatric ward and the abuse of power I felt could occur on these wards. For example, forced medication or seclusion for 'unacceptable behaviour'; and being treated with reduced dignity and power. I was hoping to learn about the needs of patients residing on an acute ward, and whether these could only be safely addressed within a secure environment. I was hoping to understand what it may feel like for staff and patients on the ward.

1.2.2. Interest in ward observations and psychodynamic literature.

Before I decided upon my research project I attended a conference where my current field supervisor presented a ward observation rooted within a psychodynamic framework, which was fascinating (see Blacker, unpublished thesis, 2009). This fitted with my passion for psychodynamic approaches and fortunately I was able to gain a placement within a psychodynamic setting for a period of two years. During this time I learnt through working

with two individual clients, attending weekly seminar groups where theory was discussed with clinical examples, and joint supervision with a Principal Psychotherapist and peer. The idea of taking these ideas into another setting, such as an inpatient ward, to develop an understanding of ward culture was really exciting. My academic supervisor encouraged me to read paper's by Bick (1964), Bion (1955) and Menzies Lyth (1960) to orient myself towards the observational approach and I read the works of Hinshelwood and Skogstad (2000), Goodwin and Gore (2000), and Jones and Wright (2008), providing more clinical examples of utilising a psychodynamic observation method for research purposes. The prospect of carrying out research without relying on standardised measures was appealing as I had become disheartened with the limits of measures relying on numbers and statements that seemed to miss out the dynamic quality of change within psychotherapy. I hoped that the observational method, drawing upon the counter transference of myself and participants within my research team would add another dimension to the current literature on ward atmosphere.

2. Reflecting on My Preconceived Ideas and How They Changed

Prior to conducting the observations I attended a meeting with the staff group to discuss the project and answer their questions. I was met with a range of responses during this meeting, such as avoidance of gaze, laughter, whispering with colleagues, questioning my credentials and the science behind the project; and whilst this felt quite anxiety provoking I could also see the justification in the questions being raised.

I approached the observations with an attitude of holding an open mind, I was aware of the concepts of free floating attention and my role as an observer to use the experience to learn about the ward. However I was also aware of some preconceived ideas; such as my

views on the state of inpatient wards, my knowledge of other observation projects in the field and my apprehensive feelings towards the staff group following the meeting.

I noticed that during my observations on the ward I was caught between thinking that a secure ward was the only place to ensure patients' safety, juxtaposed with thinking that the environment was part of the problem as to why patients did not make significant changes to their lives and returned to the ward. Thoughts that I had in support of secure wards were based on a concern that otherwise patients could inflict harm on themselves or they may be vulnerable in society due to their presentation and how they appeared naive toward their effect on others and vice versa. I also realised that whilst I used to acknowledge the role of biology within mental health problems, I gave it little weight, supporting the psychosocial model much more favourably. I think that my experience on the ward; the opportunity to be in that pressured environment and see how I identified with the staff members on occasions helped me think from a less opposing position and appreciate the role of other professionals within the MDT and their beliefs or their available options. However, I also noticed the limits of the environment, which were detailed within the research report.

Previous experience and prior knowledge and assumptions about the research would have also affected me at an unconscious level. Although I purposefully avoided conducting my literature review and researching different theories for my research report until after the analysis, I was attending university throughout the project and seminar groups in the psychodynamic placement that directed me to reflect on my clinical work in line with the theory each week.

2.1. Past experiences.

Strauss and Corbin (1998) encourage researchers not to disregard their own

experiences, which may have shaped certain thoughts they have, but use these as a framework on which to draw comparisons and search for dimensions upon. Sternberg (2005) advocates using experiences conceptually to order the data but to avoid treating them as facts. The function of a supervision group was to ensure that ideas and formulations were discussed openly and confidentially according to the material presented. Menzies Lyth (in Klein, 1989) addressed the importance, originating from a principle of the Tavistock Institute, of having a group to study a group: 'As regards transference and countertransference, two people can be very useful in helping each other to sort them out, check and recheck them and disentangle each other from relationships that interfere with work or from attitudes inconsistent with consultancy' (p.39). The academic supervision offered a slightly different means of analysis, where latent or unprocessed issues were discussed and more time was spent considering the dynamic between the material presented by myself and more personally how that affected me or what emotional response in me that material had triggered. Therefore the two distinct supervision settings offered something different to the meaning making process, making it clear to me why the academic supervisor had remained separate from the supervision meetings during the observations. Also, due to the sensitive nature of some of the issues discussed within academic supervision it would not have been appropriate to discuss those within a group, where the space there was prioritized for the discussion of the clinical material.

3. Personal and Diagnostic Transference Issues

'Freud's ideas developed from seeing transference as an obstacle, to seeing it as an essential tool of the analytic process, observing how the patient's relationships to their

original objects were transferred, with all their richness, to the person of the analyst.'

(Joseph, cited in Spillius, 1985, p.156)

Casement (2002) distinguishes between 'personal countertransference' that includes what is personal to the observer's own history and 'diagnostic countertransference', which can tell us something about the patient. Discussions with my academic supervisor helped me understand the complexity of using myself as a research tool; and that whilst my personal experiences will have shaped me and made me sensitive to certain material more than others throughout the observations that did not make that data redundant. Rather, projective identification as a concept was used to explain how certain issues that I was more emotionally responsive to on the ward, or had strong thoughts about, were likely to have a personal element to them, but were also likely to be issues relevant to the ward (A. Kurtz, personal communication, February, 2012). Therefore, rather than conceive of personal and diagnostic countertransference as distinctively separate, we explored the complexity of the situation and how both types of countertransference were involved.

During the observations I had anxieties about missing something important and doing a good enough job. I worried about whether the location of the observations was sufficient, especially during a quiet observation session. In hindsight it felt that I was picking up on the cultural attitude of the ward to look busy. This fit with the idea that busyness equalled worth or importance. This anxiety continued into the supervision discussions where I was concerned when the group was late starting one week that something crucial would be missed from our discussion. More frequently I was concerned about how as a group we explored and elaborated upon certain material more than other parts. Then during academic supervision and during the analysis I was apprehensive about ensuring the data was viewed

with equal attention. Discussions with my academic supervisor enabled me to see how my personal traits, such as perfectionism and conscientiousness, were also making me anxious about the task at hand. I originally had ideas for themes including 'anxieties about the project' as there were patterns within the material also suggesting the staff group were anxious about my presence. For example suspiciousness, hostility and avoidance of the staff group towards me was detailed within the process notes. However, we considered that rather than make up a theme based on this it would be better to integrate my subjective experiences within the other themes where relevant. This process also enabled me to keep check of my own standards and anxieties about the project that were not necessarily relevant to the formulation for the ward.

4. Experience of Observing on the Ward

Reflecting back on the experience I enjoyed the process and found the experiential learning fascinating; I felt that it altered my way of thinking and feeling which I shall attempt to articulate throughout this reflection. That is not to say I enjoyed every experience or interaction that occurred, but that the more discomforting experiences were intrinsic parts of the process that enabled me to gain some insight into the dynamics of the ward environment. In particular, feeling fearful of certain patients made me quite anxious to return to the ward each week and I was always met with a sensation of relief when I had got through an observation session without any unexpected crisis. The occasions where I felt most exposed were when patients spoke to me in a sexualised way, which led to many feelings, including shame. I do not believe that I would have *felt* this, and consequently learnt in the same way from interviewing staff, for example. Bion (1964) describes the task of psychotherapy to help trainees live with their emotional pain and suggests how intellect can be used defensively

(cited in Sternberg, 2005, p225). The impact of such an interaction helped me discuss this within supervision and consequently analyse and discuss the data in the way that I have. For example, incorporating some literature on post traumatic stress disorder felt relevant considering the potency of what I experienced, which led me to consider the unprocessed stress, shame and fear the staff group may be experiencing without any supportive outlet to help them.

As my feelings state varied during the observations and I was observed to be identifying with the different groups it was interesting to note when I identified more heavily with the staff group. The results section of the report described the different feelings I experienced and when they occurred. However it was interesting to report here that as the observations were coming to an end the anxiety of feeding back the results to the staff group drew upon me. I was also feeling indebted to them for their generosity and braveness for allowing me to conduct my research on their ward. Again, both supervision outlets were used to think about these dynamics and how I could tolerate such feelings, whilst maintaining the task of the observations.

4.2.Being pulled out of the observer role.

I was aware that I was observing patients on a ward and that the environment was having an influence on how they behaved and I as an observer was also implicated in that mix. Chiesa (1993) chose not to use the word 'neutral' when describing the role of the observer as it implies that the observer does not have an influence on the environment. Chiesa points to the sociology of knowledge (Berger & Luckmann, 1971), radical constructivism (von Glasserfeld, 1984) and new cybernetics (von Foerster, 1982) to argue that *'we cannot conceive of an external reality without taking into consideration the*

observer's function in creating it' (cited in Hinshelwood & Skogstad, 2000, p. 66). During the supervision group we spoke about the influences I would be having on the ward and how people interacted with me differently or avoided me, which were interesting ideas to discuss during the analysis.

There were times where I was pulled out of my observer role; occasionally I was aware of this and at other times it only became apparent when a member of the supervision group pointed it out. These instances were analysed within the context that they occurred; such as whether I was responding to an urge to be 'doing'; or whether I felt compelled to act on my feelings. Times where I maintained the observer stance often involved tolerating uncomfortable feelings and not acting on them, for example, avoiding making eye contact and getting into a conversation with a member of staff who I had spoken to the previous week. On another occasion I refrained from justifying myself to a member of non ward staff who accused me and staff members for sitting around. This became easier to do after supervision discussions highlighted my unconscious behaviour in responding to questions and making conversations with members of staff.

5. Learning Through the Analysis of the Data

The analysis of the data provides an illustration of how my conscientiousness and anxieties interfered with the task. In hindsight I can see that my 'errors' were based on my attempts to be rigorous with the method; such as transcribe my meetings with my academic supervisor to ensure that I acted upon what we discussed and my attention to detail when following Braun & Clarke's guide (2006). During the analysis I analysed each transcript separately as I believed that was necessary to ensure that I gave all the data 'equal attention' and was not creating themes in observations just because I had found them in a previous one.

However, this resulted in lots of theme names (54) which then resulted in a time consuming exercise of trying to collate themes and colour code data extracts. I also found that when I became concerned about the time frame – even though I had a lot of time to analyse my results – this became over bearing and stifled my creativity. Academic supervision was pivotal in being able to recognise the pressure I was under and find ways to enable me to step back from the work, contain my anxieties and encourage me to continue with the process.

6. Grounding the Intersubjectivity in the Observations

Criticisms of this approach are that it relies heavily on subjective experience. Sternberg (2005) argues that clinicians gain invaluable skills through observing infants. She argues that a competent clinician would be emotionally open and distinguish between their personal and clinical countertransference to reflect on what is happening and utilise appropriate supervision (p. 218).

I kept a reflective journal which helped me track my own thoughts and reflections throughout the research process, whilst also attending the weekly supervision group. My academic supervisor maintained a neutral stance at this point by not attending the supervision group meetings or meeting with me until after the observations had completed. This was to ensure methodological robustness and offer more distance and objectivity when discussing the data with me. All our supervision meetings were recorded, which tracked the meaning-making process of how the data became themes. I kept a rigorous method of detailing how my theme names changed shape to ensure that I knew where in the observations evidence for each theme came from. This was important considering the aforementioned issues about personal and diagnostic countertransference and how previous experiences can unknowingly influence researchers of any orientation (Morrow, 2005).

Furthermore, issues and ideas that needed more help and support unpacking and developing suggested that the results were grounded in the co-creation of meaning making within both the supervision group and during academic supervision. I did not go into the observations with any hypotheses and the origin of meaning making recorded within the results table illustrates how ideas were developed.

7. *Concepts within the Psychodynamic Literature Related to the Experience*

7.1 Introjection and projection.

Klein (1959) points to the work of Freud and Abraham in discovering the significance of 'introjection' and 'projection' in mental life. Klein argued that these processes, activities of the ego, began immediately after birth, hence in her definitions she refers to a child:

'introjection means that the outer world, its impact, the situations the infant lives through, and the objects he encounters, are not only experienced as external but are taken into the self and become part of his inner life'...

'Projection, which goes on simultaneously, implies that there is a capacity in the child to attribute to other people around him feelings of various kinds, predominantly love and hate.'

(Klein, 1959, p. 250).

In particular, the sub-themes 'getting inside the mind of the other' and 'provocatively using words' were describing these processes. Bion (1964) emphasised the archaic communicative purpose of projective identification and described the concept of 'maternal reverie' as the mother responding to the parts of the baby in distress that he puts into her, via projective identification (cited in Etchegoyen, 2005, p. 598). The powerful feelings I

experienced when observing helped me formulate how the patients and staff members were feeling at a primitive level, as I identified with both groups throughout the observations. Possible explanations for their behaviour, which could be interpreted as defensive manoeuvres aimed to protect them from those feelings were also formulated in this way. Ogden (2001) talks about the analyst[6] using reverie experience as an experiential mode for learning about the patient and their transference relationship with the analyst. Reveries are described as visceral in nature – for example thoughts and sensations, that are actually experienced in the analyst and are informative of what the patient is experiencing and trying to communicate (cited in Sternberg, 2005).

7.2. Countertransference.

Heimann (1950) introduced the idea of the counter-transference being used as a tool in psychotherapy, which is fundamental to individual therapy, and has since been used in observational studies. Heimann uses the term to represent all of the feelings the analyst experiences towards their patient (p. 81). The job of the analyst, which differs to other people in a relationship with the patient, is to:

'sustain the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection'

(Heiman, 1950, p.82).

It could be suggested that the role of the observer was to withhold the intense feelings during the observations and use the supervision group and academic supervision to reflect and

[6] The trainee would apply this concept to the 'observer's' task, rather than just a classic analytic situation

understand the dynamic processes. It was possible that the patients and staff group were caught up in projections of each others' unwanted feelings and the observer was a temporary vessel for these to be located.

8. Further Methodological Comments

Criticisms about the generalisability of qualitative studies are well known (Willig, 2008). More specifically to the observation methodology are claims that visiting the ward for an hour over six weeks is not representative of what actually happens. Hinshelwood and Skogstad (2000) suggest that the culture of an organisation, although changeable, will permeate throughout the observations. They add that unlike infant observations that usually track developmental change over two years, the aim of an organisational observation is to track the culture in the moment; furthermore it would take much longer to notice the effects of a cultural change. The consistent findings from the research literature, which were reviewed after the data had been collected and analysed, support the idea that what was detected within the current study is representative of acute inpatient wards at this point in time.

9. Professional Development

I have enjoyed working in a different capacity when conducting my research and found it fascinating going onto a ward in a role other than a psychologist in training. I am fortunate to be able to go back to the ward and work with the staff in a consultancy role, facilitated with an experienced clinician. I feel that these opportunities and experiences will be invaluable to me and of ever more importance as the roles of a psychologist are expanding and more commonly involving working within an organisational context. I feel so grateful

being granted the opportunity to work within a psychodynamic setting and found such a passion in conducting research in this area. It has felt hopeful being able to use concepts discussed within an individual therapy context and broadening them out to working with an organisation. I hope that the method proves beneficial to all the participants within the research. As Bain and Barnett (1986) stated, I hope that through studying an organisation it can encourage the people within the system to stop and think, and encourage them to see behaviour occurring as a result of relationships (cited in Barnett, 2010).

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Section E

Appendices

Submitted April 2012

By

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To The University of Leicester, School of Psychology, Clinical Section,

In partial fulfillment of the degree of,

Doctorate in Clinical Psychology

Appendix A: Guidelines to authors for target journal for literature review

Journal of Applied Psychology®

Editor: Steve W. J. Kozlowski
ISSN: 0021-9010
eISSN: 1939-1854
Published: bimonthly, beginning in January
ISI Impact Factor: 3.977
Psychology - Applied: 3 of 69
Read Sample Articles
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Editorial by Steve W. J. Kozlowski, Editor (PDF, 28KB), January 2009

Please consult APA's Instructions for All Authors for information regarding

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Submission

Prior to submission, please review the submission guidelines detailed below.
Starting in 2012, the completion of a Submission Checklist (PDF, 70KB) that signifies that authors have read this material and agree to adhere to the guidelines is now required. For new submissions, please be sure to include the submission checklist on the first page of your manuscript (and data transparency table at the end if required). Revisions do not need the checklist or table.
Manuscripts that do not conform to the submission guidelines may be returned without review.
All efforts should be undertaken to submit manuscripts electronically to the editor. Files can be sent in Microsoft Word, in WordPerfect, or as a PDF file. The version sent should be consistent with the complete APA-style printed version.
Authors without Internet access should submit a disk copy of the manuscript to
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Manuscripts should be logically organized and clearly written in concise and unambiguous language. The goal of APA primary journals is to publish useful information that is accurate and clear.

Two primary types of articles will be published:

- **Feature Articles**, which are full-length articles that focus on a theoretically driven empirical contribution (all research strategies and methods, quantitative and qualitative, are considered) or on a theoretical contribution that can shape future research in applied psychology, and
- **Research Reports**, which are original in their empirical or theoretical contribution but smaller or narrower in scope than a Feature Article. Research Reports can also be useful replications.

The journal also has a history of publishing theoretical monographs on occasion. Monographs are substantial and significant conceptual contributions (as determined by the Editorial team). As such, monographs are relatively rare.

Authors should refer to recent issues of the journal for approximate length of Feature Articles and Research Reports. (Total manuscript pages divided by three provides an estimate of total printed pages.)

Research Reports are limited to no more than 17 manuscript pages of text proper; these limits do not include the title page, abstract, references, tables, or figures. Different printers, fonts, spacing, margins, and so forth can substantially alter the amount of text that can be fit on a page. In determining the length limits of Research Reports, authors should count 25 lines of 12-point text with 1-inch margins as the equivalent of one page.

Authors should indicate whether their manuscript is to be considered as a Feature Article or a Research Report at the time of submission; the Action Editor may suggest that a Feature Article submission be pared down to Research Report length.

For the reader to understand the importance of the research findings, authors should indicate in the Results section of the manuscript the complete outcome of statistical tests, including significance levels, some index of effect size or strength of relationship, and confidence intervals.

Masked Review Policy

The journal will accept submissions in masked review format only. Author names and affiliations should appear in the cover letter but not anywhere on the manuscript. Authors should make every reasonable effort to see that the manuscript itself contains no clues to their identities. Manuscripts not in masked format will be returned to authors for revision prior to being reviewed.

Data Transparency Policy

APA requires that all data in their published articles be an original use. Along with determining the appropriateness of any submission, the editor and reviewers also have a role in determining what constitutes "original use." Any previous, concurrent, or potential future use must be brought to their attention.

In order to preserve masked review, authors should include a data transparency table in the manuscript which details how and where the data collected was/will be used. Authors may also put in any other clarifying information they wish, as long as it can be done fairly anonymously. Any identifying information, such as authors' names or titles of journal articles, that the authors wish to share should be made in the cover letter where only the editorial staff will see it.

For more information on APA's data policies, please see Section 1.09, "Duplicate and Piecemeal Publication of Data," APA***Publications Manual*** 6th Edition, p. 13–15.

Appendix B: Literature Review Search Strategies

Step 1: Consultation with mental health professionals and researchers to identify relevant resources, authors and articles.

Step 2: Initial database searches
Searches were conducted in PsycINFO, Scopus, Web of Science and Science Direct. Plus the Cochrane Database of systematic reviews was searched revealing three previous reviews. The various combinations of the following terms were used:

	Search terms (1, 2 and 3 combined with 'AND' syntax)
1	'Client' or 'participant' or 'individual'
2	'therap*' or 'treatment outcome' or 'satisfaction' or 'feedback' or 'experience*'
3	'psycho* intervention' or 'psychosocial' or psycholog*

Database	Criteria/limiters	Articles Retrieved	Further refinements	Titles and abstracts scanned
PsycINFO	English language, peer reviewed, exclude dissertations, narrow by treatment outcome		N/A	3 632
Scopus	English language, key words		Exclude life and physical sciences	3 910
Web of Science	English language	831	psychology	177
Science Direct	Searched for 'therap* outcome' within 'client feedback' results	37 484	Limit to journal; limit to mental health; limit to health care	607

Total articles	8 326
Relevant articles after abstracts scanned	62
Total number once duplicates removed and inclusion criteria applied	24

Appendix C: Trainee's statement of epistemological position

Reflexivity is important to consider in terms of the authors position when reviewing and critiquing the literature; the impact she has on the research and vice versa (Morrow, 2005). The author is a trainee clinical psychologist who has worked with various client groups and been involved in collecting feedback from clients via questionnaires, semi structured interviews and during therapy. She has an interest in organizational culture and relational dynamics. She has no previous experience of research in this area.

The method within the research report is based on a model of clinical pragmatism. The trainee adopted this approach in that she was not attempting to find a 'truth' about her mind or the ward, but was instead interested in whether a relationship could promote growth. Maxcy (2003) described the aim for pragmatists were to achieve a better, richer experience, rather than a 'truth' independent of human experience. The method is based on an attempt to gain a detailed knowledge of what is being observed through intersubjectivity and drawing upon the tool of counter transference (Heimann, 1950). Maxcy (2003) regarded any approach considered affective to be capable of exploring such phenomena, including scientific analysis, artistic exploration and social negotiation.

References

Heimann, P. (1950). On Counter-Transference. *International Journal of Psycho-Analysis, 31*, 81-4

Maxcy, S.J. (2003). Pragmatic threads in mixed methods research in the social sciences: the search for multiple modes of inquiry and the end of the philosophy of formalism. In A. Tashakkori and C. Teddlie (Eds.), *Handbook of mixed methods research in social and behavioural research* (pp. 51-87). London: Sage

Morrow, S. L. (2005) Quality and Trustworthiness in Qualitative Research in Counseling Psychology. Morrow, Susan L. Journal of Counseling Psychology, Vol 52(2), 250-260

Appendix D: Methodological Features of Each Study (Quantitative)

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**
Details of sampling method given	1	1	1	1	1	1	1	1	1	1	0	0	0	1	1	1	1	1
Details of sample demographics given (/2)	1	2	2	1	2	0	2	2	2	2	2	1	2	2	2	2	0	2
Representativeness of sample stated	1	1	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0	1
Reliability of measures tested / reported	1	1	1	0	1	1	1	1	0	1	0	1	1	1	1	1	1	1
Validity of measures tested / reported	1	1	1	0	0	1	1	1	0	1	0	1	1	0	0	1	1	1
Reasons given for missing data	1	0	1	0	0	1	1	0	1	1	0	0	1	1	1	1	1	0
Significance levels or confidence intervals given for results	1	1	1	1	1	N/A	1	1	0	1	1	1	1	1	1	1	1	1
Effect size calculated and reported	0	1	0	0	0	N/A	N/A	N/A	0	0	0	0	1	1	1	1	0	1
All study questions / hypotheses answered in results	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Exclusion/inclusion criteria stated	0	0	1	0	1	0	1	0	1	1	0	1	0	1	1	1	1	0
Limitations of study acknowledged	0	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Total Score / 12	**8**	**11**	**10**	**5**	**9**	**5**	**10**	**9**	**7**	**10**	**5**	**7**	**9**	**11**	**11**	**11**	**8**	**10**

Studies 1-11 therapeutic outcome; 12-18 progress feedback.

A score of 2 indicates demographic features and diagnosis or presenting problems were detailed
A score of 1 indicates presence of design feature.
A score of 0 indicates design feature was not present or insufficient information given to accept design feature

Appendix E: Quality Details of Qualitative studies

Author	Process and reflexivity of the analysis	Validity: Triangulation? Incorporate ppt views?	Are negative cases sought?	Does analysis explain behaviour? How well does explanation fit with what we know?	How familiar are researcher & ppts? Are a wide enough range of activities observed?	Is it clear what is evidence & what is interpretation? Are examples of text given?	Did they make use of quantitative evidence?
19) Sibitz (2007)	Not described how themes emerged or what the analysis involved. Researchers were not reflexive about their influence as psychiatrists.	No feedback to pptns was reported, nor were their views on results included.	No	Analysis fit with other findings on positive aspects of groups, e.g. info, learning off others, competent facilitator etc.	Not clear if psychiatrists knew the patients. 9 sessions + 2 focus groups. Authors said Pptns who referred from leaflets may have had less cognitive problems than of the pop. Pptns selected for focus group on who had made impressions on psychiatrist, therefore others views not heard. Selection bias?	Quotes & words are given in speech marks, but no participant number or name, or transcript reference. At one point it describes a ppnt statement & goes onto talk about increased self esteem, however it is not clear if this is evidence or interpretation.	Descriptive stats were done.

20) Lambert (2007)	Systematic approach to analysing data. Reflexivity & subjectivity acknowledged & influences between research and herself.	Ppts read transcripts & supervisor commented on these. Not clear if this influenced or altered any of the findings. Investigator describes going between themes & text & altering accordingly.	The author describes numbers of ppts which a theme was relevant to.	The introduction & write-up speaks to the reader & ppts in a client focussed & empowering tone. Ppts are reported to have said the research experience & reading of the transcripts further validated their experience.	The investigator had contacts with professionals in the services involved & the initial interview discussed expectations, fears & hopes. The ethics process was described & thoroughness of research & aims clear. Not sure if the sample is representative of those clients seeking counselling services in these areas.	Eg's are used to illustrate findings & investigator is reflective about when she was a 'research instrument' and how she had to be mindful of her approach. Investigator is also aware of times themes could reflect her research questions.	No
21) Anker (2011)	Process of analysis detailed. Read literature after, acknowledged prior influences & research influencing categories. Independent coding & separate	They admit it would have been better getting participants to check findings, they didn't do this.	Graphs show differences in responses between the 2 groups. Deviant cases not sought.	Their findings fit with the research literature on couples therapy and relationship being important.	Not necessarily typical for other races or ethnic groups. Also, only heterosexual couples.	Good examples of coding and text.	No.

	analysis.						
22) Nielsson (2006)	Interviews (60mins) were conducted & coded by 2 of the authors & supervised by another. Their orientations & background are briefly described.	Re-checked themes.They didn't do GT fashion of iterative of text & analysis though.	No negative cases described.	Letters were sent before interviews to encourage rich material to be brought to interview & prompt memories.	Field work	Clearly described process of computer analysis & authors coding & reading texts.	No

23) Ward (2008)	A table of the thematic structure was provided	Thematic structures were compared & discussed until a final agreed structure was found.	No deviant cases are explained.	Transcripts led to a wealth of information from ppts.	Telephone interviews were conducted. Before the interview ppts were called & the medium of telephone interview was discussed. None of ppts in this sample were described as 'fully recovered', therefore responses here may be typical of those still coming to terms with & adjusting to their condition.	Eg's given & illustrated with commentary. Reactions were classified as either positive or negative.	No.
24) Whitney et al (2008)	The authors position is not stated. Collecting the data is described & how they kept to a GT approach.	Triangulation was described & adhered to. Reading & re-reading of the material. 2 authors & the researcher analysed the texts for codes & themes & strong concurrence was reported	No	Information about perfectionism & rigidity would fit with what's known about AN. It would be comprehensible to those who participated.	Investigators appear to work in the inpatient wards also; therefore familiarity with the context would be evident. May bias findings compared to someone not involved in the organisation.	Clear examples & commentary. They stated that the aim of G.T was to find themes from the data & hold no pre-existing goals.	No

Appendix F: Studies included in the Literature review

First author and date	Method	Main findings	Limits/ Quality Comments	Contributions to the evidence base/ future directions/ clinical implications
1) Botella (2008)	(N =239). Outcome measures: CORE-OM WAS-I (Working alliance inventory) MANOVA	Symptom improvement when therapy ended in agreement with the therapist. Therapy was effective, emphasis on alliance initially in therapy.	Sample size small by final sessions; MANOVA findings to be treated with caution.	The strength of the therapeutic alliance between client and therapist from the client's view should be considered.
2) Defife (2008)	(N= 55). Semi structured clinical interview. CPPS (Comparative psychotherapy process scale) T Tests	specific technical processes were related to measures of therapeutic outcome.	Limited sample size; all treatments were from a psychodynamic service limiting generalisability.	To investigate the processes in child services and in group therapy. Importance of gaining individuals' perspective.
3) Lunnen (2008)	(N= 66). OQ-45 (measure of general psychopathology) QP (modified patient questionnaire) CSQ-8 (client satisfaction questionnaire) Regression analyses	Satisfaction was not significantly related to symptom change. Satisfaction was related to end point functioning from client & significant others.	End point functioning was based on 3 global questions so agreement could be a function of shared method variance. Retrospective data	Multiple perspectives in outcome should be sought.
4) Murphy (2009)	(N = 101 face to face; 44 online); GAF (Global assessment of	No significant differences were found between online or face to face counselling.	Clients could choose to go in the online condition (preference for	Qualitative research to explore the reasons behind some clients' outlier scores.

	functioning) CSS (client satisfaction survey; by Interlock)		technology?) Intention to treat and reliability questioned (outliers removed led to no difference in results).	Research effectiveness of online counseling.
5) Ogrodniczuk (2007)	(N = 107) Measures of satisfaction with different types of therapy (3 items of a 9-item scale).	Dissatisfaction had different effects on outcome for the two therapies.	Limits of the questionnaires. Symptom change at the time of rating was not assessed. Limits of scale only assessing 3 aspects of dissatisfaction.	Therapists should attend to individuals perceptions of the therapist, especially if they have a poor history of relationships (impacting TO).
6) Orford (2009)	(N = 742). Content analysis on sentence completion questionnaire booklets. (Alcohol treatment trial).	More comments of social aspects were found after SBNT (social behaviour network therapy) & more motivational aspects after MET (motivational enhancement therapy). Most positive general comments centred around a strong therapeutic alliance and establishing a need for change.	Researchers remained blind 'as far as possible' to conditions. Simplicity of questions asked appeared to limit interpretation of findings.	The findings have wider implications into understanding the processes of change in addictive behaviours.
7) Owen (2010)	(N = 161). Common factors model to code clients' perceptions of helpful therapist actions, from 2 open ended	Helpful actions were related to insight, relationships and information. Results suggested that insight may	No control group. No screening, monitoring or training of the therapists. No external rater checked agreement of the codes.	A distinction between the Insight and Relationship clusters suggests that therapists should not assume a

	questions.	be enhanced if accompanied by other factors (e.g. warmth of feedback).		positive therapeutic relationship leads to insight. Therapists should aim to understand clients' beliefs about how therapy can be most helpful and to tailor interventions accordingly.
8) Boswell (2010)	(N = 42). Therapist intervention use (multitheoretical list of therapeutic interventions); SPS (session progress scale)	Intervention use and session outcome led to no main effects for training variables. CBT rated as less helpful within CF approach.	Sampling method was not described. No exclusion or inclusion criteria stated. It is not clear how many patients were asked to participate or attrition.	Future research should provide a better understanding of clinician's decisions related to technique use in naturalistic settings and the integration of techniques into practice.
9) Magill (2010)	(N= 380). Comparing MI alone vrs MI with a significant other (SO). Outcome measures: alliance, fidelity, client satisfaction and engagement.	Patients and SOs reported higher alliance, satisfaction & engagement than was perceived by the therapist. Discussion around the influences of SO characteristics and drinking on patient outcomes.	Measures were not described, limiting reliability, validity and replication of the study; to be viewed as exploratory.	Future studies should examine the role of SO support, motivation, and drinking variables in relation to MI process and outcomes.
10) Manne (2010)	(N = 203). Therapeutic realization scale; Emotional arousal scale of the therapy session report. WAI (therapeutic alliance); BDI (depressive	Positive affect and therapeutic realizations & bond appear to be protective for women with depressive features & negative affect. Negative affect played a strong role in predicting subsequent	A secondary analysis. Their model differed to other GMP (generic models of psychotherapy) studies of therapy processes. High refusal rate (54%).	Evaluating universal change processes in other psychological treatments for patients diagnosed with gynecological cancers & other forms of cancer.

	symptoms).	depressive symptoms.		
11) Andersen (2007)	(N = 227). Self report satisfaction and group cohesion ratings. Various outcome measures, including emotional distress & social adjustment.	Cohesion covaried with change across psychological, and health domains. Cohesion was displayed through mechanisms other than treatment technique. Treatment satisfaction ratings offered very little on how this relates to intervention or technique.	Limited measures used, and they did not assess negative experiences.	Investigation of therapeutic processes, to determine the most efficacious psychological treatments for patients with cancer.
12) Halford (2012)	(N = 134 couples). DAS DAS-7 (dyadic adjustment scale; briefer version). Algorithms and predictions of couple therapy success based on previous database findings.	Lack of improvement initially in therapy predicts the final outcome	Overall agreement of husbands and wives was moderate, therefore reports given on relationship adjustment gave different classifications of outcome.	To assess what criteria is used predicting outcomes?
13) Reese (2010)	(N= 46 couples). PCOMS – ORS (outcome rating scale) and SRS (session rating scale) at the start of every session.	FB couples clinically significant, higher and faster rates of improvement that TAU.	Trainee students led the sessions with limited training on PCOMS. They did not have to follow a manual & there were no session limits. Multiple outcome measures were not used and didn't look at outcome (e.g. couple stay together).	Future research should compare administering feedback every session compared with every second or third session.

14) Anker (2009)	(N = 410 couples). Assessing PF to therapist and couples and measuring marital adjustment (Locke Wallace test)	Feedback (FB) outcomes were more improved and positive couple effects were found at follow up (lower rate of separation of divorce at 6 months post therapy).	The authors didn't monitor couples relationships across therapy; nor at post therapy; big attrition rates.	Authors state FB can be a preventative intervention applied in any setting or therapeutic modality.
15) Harmon (2007)	(N= 2819). Looking at client deterioration across 3 interventions in FB or no FB conditions	FB to therapists reduced deterioration rates and improved outcomes across clients, especially those predicted as not on track (NOT).	Single self report measures used. Therapists used the FB information in various ways (did nothing; used it to guide treatment; discussed issues with the clients).	Further research needed across a range of clinics and client groups.
16) Reese (2009a)	(N= 74 x 2). A continuous FB system (PCOMS) was used to determine if change was more reliable and found quicker than with no FB	Those in the FB condition had significant treatment gains compared to TAU	Problems getting ORS scores for the no FB group, which may have skewed data favourably for the FB group. Large number of clients excluded.	Use measures with populations other than Uni students (less severe problems)
17) Reese (2009b) (PF)	(N= 95). FB tools in supervision. PCOMS and SOS (supervision outcome survey).	FB group showed greater improvements. Trainee self efficacy and outcome was stronger in the FB condition, suggesting FB may facilitate a more accurate assessment of one's skills.	Threats of internal validity comparing clients' outcomes given the diversity of presenting problems and level of severity.	Implications; usefulness of FB to capture a more accurate description of client's views rather than rely on trainee's reporting and anxiety to disclose mistakes.

18) Slade (2008)	(N = 1101). Timing of FB (with or without the use of clinical support tools [CST]).	Neither immediate direct client progress feedback nor more immediate CST feedback enhanced client outcomes, but the same level of change was reached in fewer sessions in the immediate FB condition (than the delay).	Effects were clinically enhanced using CST to elicit information from clients NOT.	A more standardized method was suggested to track clinician feedback.
19) Sibitz (2007)	(N= 103). To explore patients' views about wanted & unwanted effects of group psycho-education; thematic content analysis on patients narratives; and focus groups using 'inductive formation of categories to analyse the text.'	Increased knowledge led to sense of mastery; knowledge, reflection & support from others led to change; change depended on stable mental condition, clear topic aims & a moderator who performed well	Questionnaires were not detailed inhibiting replication.	patients' viewed being in a clinically stable condition as important, therefore it raises questions of usefulness of these groups within psychiatric wards/hospitals.
20) Lambert (2007)	(N=8)Interpetive hermeneutic framework, based on thematic analysis of interview data. Investigating individuals' perspectives of counselling and how these change over time.	Initially clients uncertain, and hoped for someone non judgemental; during therapy themes emerged of ordinary friendliness; level of therapist skill & a fear of delving deeper. After clients developed more self awareness and positive relationships with others.	It was not clear how many sessions or when the final interview took place. Inclusion & exclusion criteria was not stated	Consider how people treated during assessments by professionals

21) Anker (2011)	(N=382). 3 open ended qu's were asked about client experiences 6 months after therapy. ORS & SRS. Locke-Wallace Marital adjustment test. Thematic analysis	Individuals prefer personable and active therapists who maintain neutrality. Dissatisfaction with therapist who did not provide enough structure or challenges.	Modal sessions was 2. Investigation of previous feedback as helpful was only a tick box (limited information).	'Were therapists who regularly received feedback more responsive to clients' wishes regarding the scheduling of sessions?
22) Nilsson (2007)	(N=32).To describe the therapy experiences (CBT and PDT). Semi structured interviews and a narrative retrospective design.	Differences were found in the kind and quality of outcome reported; some experiences common to both	Pre group differences were not explained. Unclear how/why assigned to each group	Therapists should use sensitivity to decide whether the therapy is suitable to the patient.
23) Ward (2008)	(N=25).Thematic analysis of interviews of peoples' (with ME) experiences of counselling	Comments were made on the therapists characteristics and the way interventions were carried out	Unclear if therapists' experience or interventions were confounding variables.	Implications: clinicians should have a good understanding of their specialist area
24) Whitney (2008)	(N=19).Grounded theory. Individuals' experiences of participating in CRT (cognitive remediation therapy).	FB was generally positive. Not just focussing on the problem issue (i.e. food) was helpful. It helped reduce traits such as perfectionism and rigidity.	No control group; Limited feedback on negative appraisal	Ensuring that clients understand the language and don't just intellectualise and repeat what the therapists said

Appendix G:

Research Pack:

(1) Observation Poster

(2) Participant Information Sheet for staff

(3) Participant Information Sheet for the Supervision Group

(4) Staff consent form

(5) Supervision group consent form

Observation Poster

Research Project Title:

The psychodynamic approach to observing organisations: towards a psychosocial intervention

OBSERVATION SESSION NOTICE

Emma Tilbury, Trainee Clinical Psychologist, will be visiting the ward to carry out an observation session for above research project. The details of the next observation session are, as follows:

Date: *day and date entered here*

Time: *time entered here*

Location: *location entered here*

Duration of Observation: 1 hour

Please be reminded that you are under no obligation to take part in the observation session. If you would prefer not to take part, please avoid the location stated above during the time specified. If you would like further information about the nature of the project, please speak to a member of staff or myself.

University of Leicester

Staff Participant Information Sheet

I would like to invite you to take part in a research study that I am doing as part of my clinical psychology training. Before you decide whether or not to take part, it is important that you understand what the research is about and what it could mean for you. Please read the following information carefully. If you have any questions about the research please contact me by email, phone or at the address provided. Please take your time to decide whether or not you want to participate.

Title of study
The psychodynamic approach to observing organisations: towards a psychosocial intervention

Principal Researcher
Emma Tilbury, Trainee Clinical Psychologist, University of Leicester.

Co-Researchers
[redacted]

What is the purpose of the study?
The first purpose of the study is to consider the ward atmosphere on an acute inpatient unit for people with complex mental health problems. This is to be achieved by using an observation methodology (rather than a questionnaire or interview, for example). The second purpose of the study is to process the observational analysis and interpretations and consider how to present the findings so that they can be fed back to the staff group involved in the study as part of a follow on project.

Why an observational methodology?
Much of the recent literature on ward atmosphere relies on the use of questionnaire studies or interviews with members of staff. Compared with a questionnaire study, using an observation methodology allows a more flexible approach, encouraging an in-depth consideration of the subtleties of the ward environment.

What is ward atmosphere?
The term ward atmosphere has previously been defined in many different ways. In general, it is an umbrella term for any social, physical or functional aspects of the ward environment, which may impact on staff and patients.

Has the study been approved?
Yes. The School of Psychology at the University of Leicester, my academic and field supervisors, plus the Research and Development Departments at [redacted] have approved this study.

It has also been reviewed and given a favourable opinion [redacted], a body appointed by the Strategic Health Authority. It consists of a number of people with various backgrounds, including health care. Their role is to consider the ethical merits of any research and whether the benefits of doing the research outweigh any disadvantages. Research cannot happen without REC approval.

Do I have to take part?
No. There is no obligation to take part in the study. Choosing not to take part will not

affect you or your role in any way.

What will happen to me if I decide to take part?
If you are interested in taking part in the study, you are invited to contact me by email, phone or at the address provided if you would like further information about the study. If you would like to arrange a meeting to discuss the study in more depth we will arrange a mutually convenient time and I will come and visit you at the unit.

Once you have had time to think about the study, I will ask if you have decided whether or not you would like to take part. If you would like to take part, I will ask you to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the observations at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me by phone or at the address provided.

During the observation session I will be sitting on the ward at the agreed location. I will not be taking any notes. Following the observation session I will go away and type onto a computer anything I can recall from the observation session.

The content of the observation notes will then be discussed during a supervision group. This group will consist of four people: myself, my supervisor at Leicestershire NHS Trust and two other clinicians who are experienced in observation methods. None of the people who are part of this group work on the ward. During the supervision sessions all individuals will be referred to by a pseudonym (fictitious name) to protect your identity. They won't have access to your information.

How do I find out when and where the observations will take place?
Before I come to the ward to conduct the observation posters will be displayed around the unit detailing where the observation will take place and on what day, date and time. These posters will be regularly updated so that the correct date and time is displayed.

How long will the observations last?
I will visit the unit on six separate occasions. Each observation session will last approximately one hour.

Will my contribution be confidential?
Absolutely. Your data, resulting from my notes of the observation session, will be treated in accordance with the Data Protection Act. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be kept separately in a locked cabinet at the University of Leicester. Any information that is kept on the computer will be password protected. Only I will have access to it. The name and location of the ward and unit will be anonymous in order to ensure confidentiality.

There may be times during the analysis when my research supervisor at the University reads through the observation material. They won't have access to your information. Your information and observation notes will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Leicester for a period of five years. It will be destroyed after that.
It is important to note that although all data will be treated in accordance with the Data Protection Act there may be instances when it becomes necessary to break

confidentiality. For example, if I observe anything that causes me concern regarding patient care then I have a duty to report this to a line manager. In the unlikely event of this occurring I will discuss my concerns with you as appropriate.

What are the benefits of taking part?
The findings of the study can be used by the Ward Manager and members of the ward to think about what is working well on the ward and areas where changes might be beneficial to the ward environment. In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to consider the most useful way to understand factors such as ward atmosphere and the social environment.

What are the potential risks?
The main aim of this study is to observe the everyday functioning of a ward environment, therefore by taking part you are not be asked to do anything different or in addition to that which you would normally do. In that sense, there are very few risks associated with taking part.

It is recognised, however, that the notion of being observed can be quite anxiety provoking for individuals. This is a natural feeling, which often lessens after the first few minutes. If however you do feel uncomfortable, and decide that you no longer want to take part in the observation, you are free to leave the observation area at any point.

I will be available for the duration of my training (up to September 2012) should you need to contact me about taking part. [redacted] will also be available should you need to discuss any aspects of the research, especially anything that you are unhappy with.

What happens if something goes wrong?
If you have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Academic Supervisor [redacted]
In the event that something goes wrong and you are harmed during the research because of someone's negligence then you may have grounds for legal action for compensation against Leicestershire Partnership Trust. Please note that you may have to pay legal costs.

What happens if I change my mind and don't want to participate?
Your participation is voluntary. If, following the observation period, you decide you would like your contribution to be withdrawn you are free to request this prior to data analysis and publication. Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

What will happen with the results of the study?
The results will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

I would like to take part. What do I do now?
You will be informed of the day, date, time and location of the observation by a poster that will be displayed around the unit.

Contact Details
Phone: [redacted]
Address: Emma Tilbury, Trainee Clinical Psychologist, [redacted]

Thank you for taking the time to think about taking part in my study.

Supervision Group Participant Information Sheet

I would like to invite you to take part in a research study that I am doing as part of my clinical psychology training. Before you decide whether or not to take part, it is important that you understand what the research is about and what it could mean for you. Please read the following information carefully. If you have any questions about the research please contact me by email, by phone or at the address provided. Please take your time to decide whether or not you want to participate.

Title of study
The psychodynamic approach to observing organisations: towards a psychosocial intervention

Principal Researcher
Emma Tilbury, Trainee Clinical Psychologist, University of Leicester.

Co-Researchers
[redacted]

[redacted]

What is the purpose of the study?
The first purpose of the study is to consider the ward atmosphere on an acute inpatient unit for people with complex mental health problems. This is to be achieved by using an observation methodology (rather than a questionnaire or interview, for example). The second purpose of the study is to process the observational analysis and interpretations and consider how to present the findings so that they can be fed back to the staff group involved in the study as part of a follow on project.

Why an observational methodology?
Much of the recent literature on ward atmosphere relies on the use of questionnaire studies or interviews with members of staff. Compared with a questionnaire study, using an observation methodology allows a more flexible approach, encouraging an in-depth consideration of the subtleties of the ward environment.

Why a supervision group?
This study aims to make use of observations that are informed by the psychodynamic approach. Inherent within this approach is the use of a supervision group. The purpose of this group is to reflect upon the observation material collected and aim to make sense of it according to a psychodynamic framework.

The supervision group will take place during the week following each observation session. This pattern will be followed until the end of the observation/supervision period.

The supervision group will comprise of myself, my supervisor from Leicestershire NHS Trust and two other clinicians who are experienced in observation methods.

Has the study been approved?
Yes. The School of Psychology at the University of Leicester, my academic and field

supervisors, plus the Research and Development Departments [redacted] have approved this study.
It has also been reviewed and given a favourable opinion by [redacted] a body appointed by the Strategic Health Authority. It consists of a number of people with various backgrounds, including health care. Their role is to consider the ethical merits of any research and whether the benefits of doing the research outweigh any disadvantages. Research cannot happen without REC approval.

Do I have to take part?
No. There is no obligation to take part in the study. Choosing not to take part will not affect you or your role in any way.

How long will the supervision group sessions last?
We will meet on eight separate occasions. Each supervision group session will last approximately one hour.

What will happen to me if I decide to take part?
If you are interested in taking part in the study, you are invited to contact me and/or my supervisor Dr. Rebecca Blacker by email, phone or at the address provided. A meeting will be arranged whereby your role in the supervision group will be discussed in more detail. This will also provide you with the opportunity to ask any questions you may have.

If you would like to take part, you will be asked to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the supervision group at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me or my supervisor by phone, email or at the address provided.

The supervision group sessions will be audio taped with your consent so that they can be typed up and analysed by me at a later date. Once typed up the tapes will be destroyed.

Will my contribution be confidential?
Absolutely. Your data, resulting from the transcripts of the supervision group sessions, will be treated in accordance with the Data Protection Act. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be kept separately in a locked cabinet at the University of Leicester. Any information that is kept on the computer will be password protected. Only I will have access to it.

There may be times during the analysis when my research supervisor at the University reads through the transcripts of the supervision group sessions. They won't have access to your information. Your information and transcripts will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Leicester for a period of five years. It will be destroyed after that.

As part of my clinical psychology training it is hoped that my research will be published. It is possible that direct quotes from you may be used in the write-up. All quotes will be kept anonymous.

What are the benefits of taking part?
The findings of the study can be used by the Ward Manager and members of the ward to think about what is working well on the ward and areas where changes might be beneficial to the ward environment. In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to consider the most useful way to understand factors such as ward atmosphere, organizations and the social environment.

What are the potential risks?
Being part of a psychodynamic supervision group can be an emotionally demanding experience. As an individual experienced in this type of supervision, it is not expected that this particular supervision group will present any challenge that is outside the realms of commonplace clinical supervision.

I will be available for the duration of my training (up to September 2012) should you need to contact me about taking part. [redacted]) will also be available should you need to discuss any aspects of the research, especially anything that you are unhappy with.

What happens if something goes wrong?
If you have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Academic Supervisor, [redacted]

In the event that something goes wrong and you are harmed during the research because of someone's negligence then you may have grounds for legal action for compensation against Leicestershire Partnership Trust. Please note that you may have to pay legal costs.

What happens if I change my mind and don't want to participate?
Your participation is voluntary. If, following the supervision period, you decide you would like your contribution to be withdrawn and you are free to request this prior to data analysis and publication. Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

What will happen with the results of the study?
The results will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

I would like to take part. What do I do now?
I will inform you of the day, date, time and location of the supervision group sessions once a convenient arrangement has been made.

Contact Details
Phone: [redacted]

Address: Emma Tilbury, Trainee Clinical Psychologist, [redacted]

Thank you for taking the time to think about taking part in my study

Consent form; staff

Name of participant:

Title: The psychodynamic approach to observing organisations: towards a psychosocial intervention.

Researcher: Emma Tilbury

I agree to voluntary take part in the above research study. I have read the Participant Information Sheet. I understand what my role will be in this research, and all my questions have been answered to my satisfaction. ☐

I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty. ☐

I have been informed that all information collected about me will be kept anonymous and confidential. ☐

I am aware I can ask questions about the study at any point. ☐

I have been provided with a copy of this consent form and the Participant Information Sheet. ☐

Data protection: I agree to the researcher writing observation notes and I have been informed that these
will be anonymous and kept confidential. ☐

I understand that the observation notes collected during the study will be looked at by supervisors from the University of Leicestershire NHS Trust. I give permission for these individuals to have access to the observation notes. ☐

I understand that if the researcher was to observe any unsafe practice it may be necessary for confidentiality to be broken. ☐

Name of participant
(print)……Signed……Date……
Name of researcher
(print)……Signed……Date……

Researcher contact details: Emma Tilbury, School of Psychology, [redacted]

Supervision Group Consent Form

Name of participant:

Title: The psychodynamic approach to observing organisations: towards a psychosocial intervention

Researcher: Emma Tilbury

I agree to voluntary take part in the above research study. I have read the Participant Information Sheet. ☐

I understand what my role will be in this research, and all my questions have been answered to my satisfaction. ☐

I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty. ☐

I have been informed that all information collected about me will be kept anonymous and confidential. ☐

I am aware I can ask questions about the study at any point. ☐

I have been provided with a copy of this consent form and the Participant Information Sheet. ☐

I consent to the supervision group being audio taped with possible use of verbatim quotations in the write-up of the research. ☐

I understand that transcripts collected during the study will be anonymised and may be looked at by supervisors from the University of Leicester NHS Trust. I give permission for these individuals to have access to the transcripts. ☐

Name of participant
(print)……Signed……Date……

Name of researcher
(print)……Signed……Date……

Researcher contact details: Emma Tilbury, School of Psychology, [redacted])

Appendix H: Description of analysis process

From Braun and Clarke (2006):

1) **Familiarise self with data** – I transcribed my data and read all the data once through and made 'initial impressions' comments after each transcript. I began re-reading each transcript checking for grammar, vocal details in recordings, such as emphasis and pauses etc, however by transcript 3 I was encouraged to skim over this as it was too time consuming for its' minimal added value to the overall project.
2) **Identify and define meaning units in the text and begin Level 1 coding**
3) **Perform Level 2 coding (summary codes)**
4) **Begin searching for themes from each transcript**. I treated each transcript separately and then collated the themes at the end.
   Process: I had a list of codes from each transcript on a piece of paper, and then tried to summarise them according to patterns that could be created into different themes. I casually decided on a theme name at this stage that would capture the gist of the themes. I was aware that more meaningful titles would have to be generated as I became more familiar with each theme and what it entailed.
5) **Writing the names of each theme onto cue cards with focussed codes evidenced on each.**
6) **Collating the themes across the entire data set:** I then placed all theme titles (54 themes generated) onto an A3 sheet of paper to look for similarities and relationships between the themes from each transcript to look for ways to group them across the **entire data set**. This began the phase of creating '**main themes'** (overarching themes) (see ***'themes from each transcript', Appendix I***). As can be seen from the document, some themes were labelled exactly the same, whilst others were titled similarly, which made it easy to group some of those themes.
7) **Re-shaping the themes and codes under the revised sub theme and over arching theme names.** Re-writing and then colour coding focussed codes under new cue cards that captured the revised theme names (which accounted for the whole data set).
8) The next stage included a **collection of main themes** (things I wanted to say about the data) and sub themes that formed these main themes (please see '***How themes across the entire data set became grouped under Main themes', Appendix J***.) At this stage my main themes were titled:

   1) Presenting in a certain way
   2) Busyness on the ward
   3) Anxieties about the project
   4) Responses in the moment changing over time
   5) Fear of Engaging
   6) The space/Ensuring safety in an unpredictable place
   7) Control
   8) Assumptions on appearance

9) **Reviewing and re-shaping the themes**

At this point some of the main themes felt strong and robust where only the main

titles would need to be re-tweaked, for example 'presenting in a certain way' became 'problems of being on the ward'. However, other main themes appeared too incongruent and were not really capturing the most significant elements of the data. The trainee and her academic supervisor discussed the data and the trainee went back to review her themes (as part of the iterative process) to search for the best way to represent those under main themes. (Please see ***'Reviewing main themes', Appendix K).*** This led to the following list of main themes:

1) Problem of being on the ward
2) Activity as a defence
3) The Imposition of Certainty
4) Fear of Engagement
5) Control

10) Finalising the themes

A further meeting with the academic supervisor and discussion of the results led the trainee to re-visit the data and ensure that the most significant points of the data were captured within the main themes. This led to the final themes entitled as the following:

1) Problem of being on the ward
2) Activity as a defence
3) The Imposition of Certainty
4) A longing for engagement despite difficulties
5) Care and control

Appendix I: Themes from each transcript (Stage 1)

(This produced a total of 54 themes)

Transcript 1 (observation 1)

1) Communication breaking down
2) (Thinking) in the moment and reflecting
3) Not really attending
4) Presenting in a certain way
5) Anxieties about the project
6) Not getting it right
7) Busyness on the ward
8) Creating Distance
9) Being disempowered

Transcript 2 (observation 2)

1) Distress
2) Understanding self and others
3) The space (observation desk)
4) In the moment and reflecting
5) Control
6) Anxieties of the project
7) Creating Distance
8) First impressions/appearance
9) 'How to be'

Transcript 3 (observation 3)

1) Time
2) Responses changing over time
3) Not getting it right
4) Busyness lacking substance (related to being 'cut off'?)
5) Benefits of experience
6) Meaningful activity
7) Anxieties of the project
8) Creating Distance
9) Being disempowered
10) 'How to be'
11) The Space

Transcript 4 (observation 4)

1) A need to be doing
2) Strong countertransferential feelings towards staff and patients
3) Looking after selves and others
4) Belonging to a group
5) Thinking about the unsaid
6) Presenting in a certain way
7) Exchanges

Transcript 5 (observation 5)

1) Exchanges
2) Splitting (later became '*environment feeling unsafe'*)
3) Containing self and others

4) ‘Hard to get the balance right between ensuring patients’ safety & respecting their dignity and privacy’
5) Pressures of time
6) Fears of connecting/engaging
7) Power of words
8) How to be

Transcript 6 (observation 6)

1) Making use of other people
2) Having a safe place
3) Slowness versus busyness
4) Conscious versus unconscious behaviour
5) Being judged
6) Roles

Transcript 7 (final meeting to think of the whole process)

1) Being in a role
2) Anticipating feedback
3) Patients’ experiences
4) Staff’s experiences

Appendix J: How themes across the entire data set became grouped under Main themes (stage 2)

1) **Presenting In a Certain Way (7 themes)**

a) Presenting in a certain way; b) 'How to be'; c) 'How to be'; d) Presenting in a certain way; e) How to be; f) Roles; g) Being in a Role.

2) **Busyness on the Ward (7 themes)**
   a) Time; b) Busyness lacking substance; c) meaningful activity; d) A need to be doing; e) Pressures of time; f) slowness versus busyness; g) busyness on the ward.
3) **Anxieties about the Project (5 themes)**
   a) Anxieties about the project; b) anxieties of the project; c) anxieties of the project; d) Being judged; e) anticipating feedback
4) **Responses in the moment changing over time (3 themes)**
   a) (Thinking) in the moment and reflecting; b) in the moment and reflecting; c) responses changing over time.
5) **Fear of Engaging (15 themes)**
   a) Not really attending; b) creating distance; c) distress; d) understanding self and others; e) creating distance; f) not getting it right; g) not getting it right; h) creating distance; i) containing self and others; j) fears of engaging; k) power of words; l) strong feelings with staff and patients; m) looking after selves and others; n) belonging to a group; 0) thinking about the unsaid.
6) **'Ensuring Safety in an Unpredictable Place (9 themes)**
   a) Communication breaking down; b) the space; c) the space; d) exchanges; e) exchanges; f) making use of other people; g) having a safe place; h) environment feeling unsafe; i) hard to get the balance...
7) **Control (6 themes)**
   a) Being disempowered; b) control; c) benefits of experience; d) being disempowered; e) patients' experiences; f) staff experiences.
8) **Assumptions on Appearance (2 themes)**
   a) First impressions/ appearance; b) conscious versus unconscious behaviour.

Appendix K: Reviewing and re-shaping the Themes and Main Themes (Stage 3)

1) **The Problem of Being on the ward**

This included some of the following themes:

a) How to be
b) Presenting In a certain way
c) Acting in a role (a combination of 'roles' and 'being in a role')
d) Appearance
e) Patient experiences

The final sub themes became:

a) Presenting in Challenging ways
b) Coping through Serene Detachment
c) Acting in a role

2) **Activity as a defence**

This included some of the following themes:

a) Meaningful activity
b) A need to be doing
c) Slowness versus busyness

The final sub themes became:

a) What is Meaningful Activity
b) Being part of an action culture
c) Retreating from the depressing reality of the ward

3) **The Imposition of Certainty**

This included some of the following themes:

a) In the moment and reflecting
b) Responses changing over time
c) Being judged
d) Belonging to a group
e) Understanding self and others

The final sub themes became:

a) Losing the capacity to empathise
b) Confusion in the moment
c) Constructing people two-dimensionally
d) Forever waiting: (This was originally within 'A Problem of Being on the Ward', under the sub themes of 'how to be' and 'patient experiences')

4) **Fear of Engagement**

This included some of the following themes:

a) Creating distance
b) Distress
c) Fears of engaging
d) Strong feelings with staff and patients
e) Exchanges
f) Thinking about the unsaid
g) Environment feeling unsafe

The final Main theme and sub themes became:

Main theme: A longing for engagement despite difficulties

a) An effort to engage: '*Hold your breath, breathe out and do the robot dance and then pull yourself together again'*
b) Engaging in a safe way – but does it meet the need?
c) Getting inside the mind of the other
d) Provocatively using words
e) Positive flipping to negative

5) Control

This included some of the following themes:

a) Staff experiences
b) Being disempowered
c) Benefits of experience
d) Control

The final Main theme and sub themes became:

Main theme: Care and Control

a) Fear of 'getting it wrong'
b) Hard to get the balance between ensuring patients' safety and respecting their dignity
c) Assuming patients can control their behaviour

Appendix L: Working diagram of themes

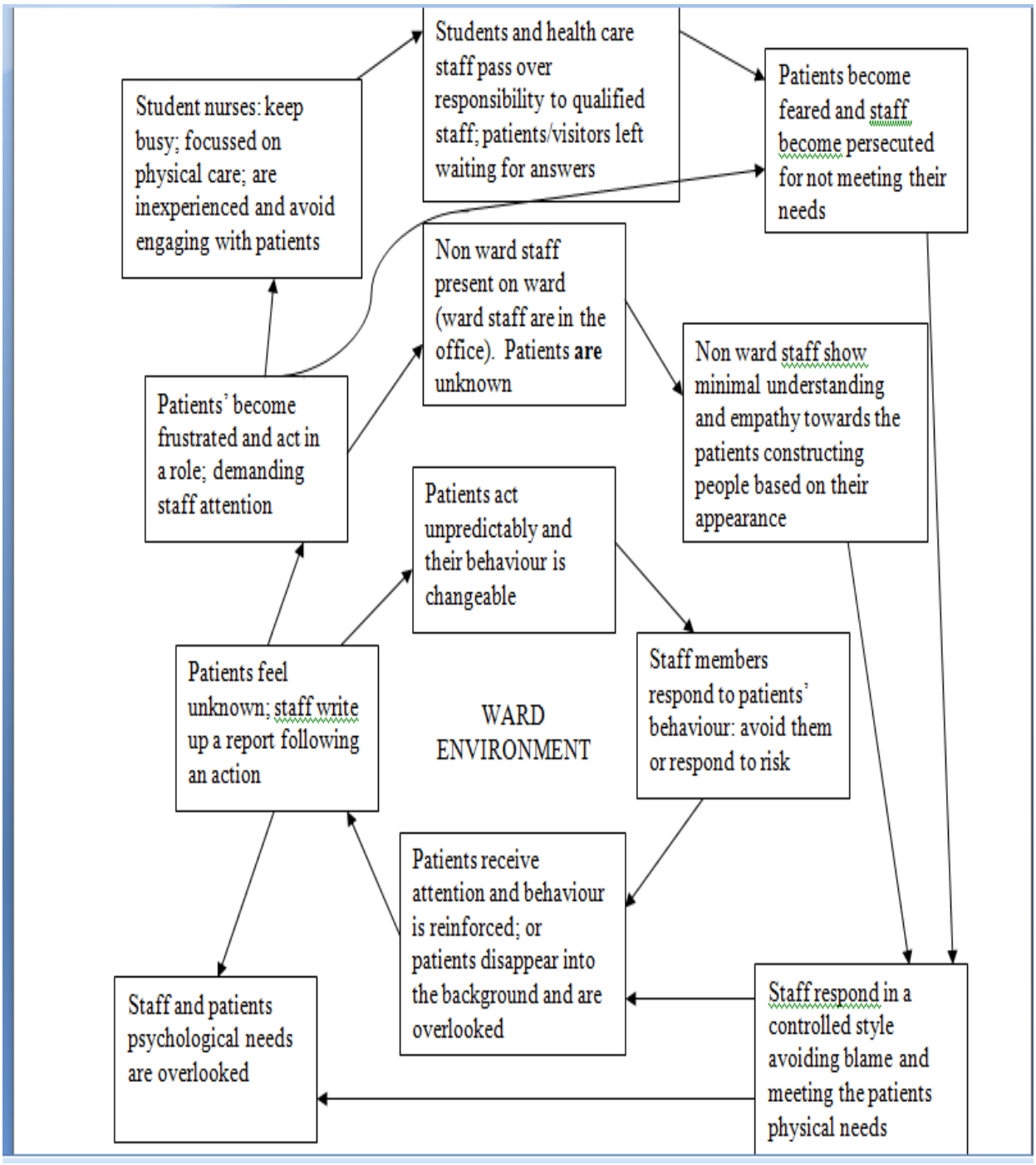

Figure 2. Reciprocal behaviour patterns between staff and patients on the ward

Appendix M: Chronology of Research Process

Summary of research activty	**Timescale**
Consult with academic supervisors and field clinicians	January- July 2010
Submit initial research proposal	June 2010
Meet with University Research committee panel	July 2010
Amend research proposal and focus on clinical placements. Prepare research pack for ethics submission and complete IRAS form	July 2010- December 2010
Meet with the ward matron and attend a staff team meeting to present research and answer questions. Attend ethics meeting. Make recommended changes.	January – March 2011
Begin observations data collection and discuss in supervisory group (8 weeks)	March – May 2011
Transcribe data	May – July 2011
Conduct data analysis	September 2011 – January 2012
Begin writing thesis, going back to the data accordingly	January – April 2012
Viva preparation	May – July 2012
Begin transforming results to feedback to participants (follow on project)	May – June 2012
Preparation for journal article and poster presentation.	June – September 2012
Conduct consultation sessions to staff group with clinician	October 2012

Appendix N: Letters to and from ethics (Identifiable information has been cropped out)

School of Psychology
[redacted]

22nd February 2011

School of Psychology
Clinical Section
[redacted]

1st March 2011

11/H0406/11

To whom it may concern,

Thank-you for your letter of recommendations for my project following my attendance at the ethics committee meeting. Please find enclosed details of the changes made to my project following this advice. The numbers in my letter correspond to the numbers in your letter under the heading 'further Information or Clarification required' (on page 3).

1) I am able to provide written confirmation to the Committee that consent will not be sought from the patients on the ward and a Patient Information Sheet will not be issued. I intend to inform all patients of why I am on the ward by presenting the project to them on two occasions at weekly Community Meetings preceding the observation. In addition, posters explaining why I will be there will be put up around the ward and I will wear an identity badge (see Appendix 9 for copy of badge) when I visit.

2) I am able to provide written confirmation to the Committee that a continuous consent mechanism will be used for staff as advised. The mechanism will be explained by a circulation email from the Ward Manager. Please see Appendix 7 for a name and signature list.

3) I am able to confirm that staff who do not wish to participate in the observations will not be reported on within the process notes or commented upon in discussions with the supervision group.

4) I am able to confirm to the Committee that I intend to inform Bank Staff and other clinical people who may be present on the ward by arriving on the ward ninety minutes before the scheduled observation is due to commence, during which time I will brief bank staff and other visitors on the procedure and the continuous consent mechanism.

5. The following amendements to the Patient Information Sheet for staff have been made:

a) I am able to confirm that instead of 'unsafe practice', the phrase 'observe any practice that was a cause of serious concern' was inserted.

b) The name of the [redacted] was inserted as having reviewed the study.

c) It has been made clear what would happen if someone could not attend one of the supervision group meetings.

d) It has been made clear that participants would be unable to withdraw their data up until the point of publication.

e) It has been made clear what the potential impact of the study on the staff could be for them.

f) It has been made clear that it is the Clinical Investigators recollections that will form the report [redacted].

g) It has been made clear how the individuals will appear in the report, i.e. how they will be referred to.

h) It has been made clear that the focus of the observations is on the general culture on the ward rather than on one-to-one interactions.

i) It has been made clear what will happen if staff do not wish to feature in the report.

j) It has been made clear that I would not go ahead with the observations in the event that a sudden death or bereavement happens on the ward.

6) I am able to confirm that all the points raised in the peer review have been addressed. Information in the introduction has been reduced and more detail was provided about the Observational Method, for example that the observer's presence will not be disguised. The findings of this study will be used to explore the reliability and validity of the method. The findings can be regarded as a contribution to knowledge about the observational method as it is the first study of this kind to assess the reliability and validity by evaluating the findings at a later stage. As of yet a body of knowledge does not exist that investigates these important issues. During the future consultation sessions (a study anticipated to follow on from this current project) the findings and how they resonate with the staff's experiences of ward life will be fundamental in considering whether the objectives of the study have been met. The initial feedback from the staff group and the way the supervision group understand and make sense of the material I take to them will provide some insight into whether the objectives are likely to be met. Alternative explanations would be considered in the critical reflection and write up of my thesis.

7) I am able to confirm that research data will be stored for longer than 3 months. Data will be anonymised and kept securely within a locked cabinet at the University of Leicester for a period of up to five years before it is wiped.

8) I am able to confirm that instead of using a Participant Information Sheet for the Ward Manager I will use a letter of permission instead.

9) I am able to confirm that my Academic Supervisor [redacted] and her contact details are as follows:

[redacted].

Work Address: Doctoral Programme of Clinical Psychology, University of Leicester,
[redacted]
[redacted] ak106@mail.cfs.le.ac.uk
[redacted]

10) Enclosed are Appendix 1-9, which include the new updated Participant Information Sheet for staff. All documents have been updated with a new version number and date.

List of changes to the project:

1) Question A6-2 of the IRAS form: I would now state that the patient group will not receive any written information and that instead of signing consent forms an 'opt out' procedure will be used. I would also state that a continuous consent form will be used for the staff group. I would also include bank staff in this procedure.

2) Question A13 of the IRAS form: I would reiterate the above point about the 'opt out' procedure for the patients. I would also clarify that it is my recollections that would be recorded and discussed in the supervision group, rather than what the participants say.

3) Question A22 of the IRAS form: I would include the potential impacts of the study on the participants in this section. I would state that I would wear an identity badge when carrying out the observations.

4) Question A27-1: I would state that I would not gain consent from patients and clearly state the 'opt out' procedure. I would also detail the continuous consent procedure for the staff group and bank staff. I would include the sentence that once consent has been gained for an observation and that data has been collected it cannot be removed until the point of publication.

5) Question A30-1: I would state the consent procedure for participants. I would state that I would be wearing a badge identifying myself as a student performing an observation.

6) Question A33-1: I would state that if patients were not fluent in English language or found it difficult to understand the project I would seek guidance on how information was usually provided to this person. If appropriate I would organise a translator to communicate with this person.

7) Question A43: I would state that data would be stored confidentially and securely for up to five years.

If you need to contact me regarding any of the information I have sent to you, my contact details are:

Telephone number: [redacted]
[redacted] et92@leicester.ac.uk
Address: As above

Many thanks for processing my application.

Yours sincerely,
Emma Tilbury
Trainee Clinical Psychologist

07 March 2011

Miss Emma Tilbury
Trainee Clinical Psychologist
Leicestershire Partnership Trust
Department of Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Miss Tilbury,

Study Title: **The psychodynamic approach to observing organisations: towards a psychosocial intervention.**

REC reference number: **11/H0406/11**

Thank you for your letter of 01 March 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be

notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Protocol	4	11 January 2011
Letter of invitation to participant	2	25 February 2011
Response to Request for Further Information		01 March 2011
Participant Information Sheet: supervision group	2	25 February 2011
REC application	69719/178903/1/241	11 January 2011
Participant Consent Form: Patient group	1	11 January 2011
Participant Consent Form: Ward Manager	1	11 January 2011
Continuous Consent Form	2	25 February 2011
Academic supervisor CV		24 February 2010
Participant Information Sheet: Ward Manager	1	11 January 2011
Participant Information Sheet: staff group	2	25 February 2011
Referees or other scientific critique report		12 January 2011
Investigator CV		01 August 2010
Participant Information Sheet: Patient group	1	11 January 2011
Participant Consent Form: staff group	2	25 February 2011
Participant Consent Form: supervision group	2	25 February 2011
Covering Letter		10 January 2011
Poster	2	25 February 2011
Design on badge to be worn on the ward	2	25 February 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H0406/11	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely