A qualitative exploration of staff responses to a formulation based upon a psychodynamic ward observation study

Submitted May 2013

By

Katherine Foley

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 the association between ward environment and patient outcome. Eleven 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 ward environment and patient outcome has been measured and how the association between the two has been explored. Clinical implications were considered as was the complexity of measuring patient outcomes. Recommendations for improving the environments of wards was also discussed.

The research explored staff responses to a formulation based upon a psychodynamic ward observation study for the initial evaluation of the psychodynamic method of observation. Data from staff discussions of the formulation during two away days was analysed using thematic analysis (Braun & Clarke, 2006). Six main themes were created to describe the different responses staff had. Staff engaged selectively with ideas in the formulation. Some responses appeared to confirm parts of the formulation, whereas other responses were considered potentially valuable for re-formulation. It was hypothesised that findings showed some preliminary evidence of the validity of the psychodynamic observation method. This was discussed with reference to the psychotherapy literature. A critical appraisal is included which describes the researcherôs reflections throughout the research, particularly influences on the process of analysis of data.

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I would like to thank the ward staff who agreed to me observing and audio recording their away days. I found the experience engaging, interesting and illuminating.

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Section B

Critical Literature Review

The association between the environment of psychiatric wards and patient outcome: A review of the literature

Prepared for the Journal of Applied Psychology

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By

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

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Literature Review Abstract
Purpose: The current mixed methods review aimed to systematically review and critique the recent literature pertaining to the association between psychiatric ward environment and patient outcome.
Method: A computerised literature search was conducted using four key publication databases from 2000 to 2012. Additional articles were identified from previous reviews. Specific inclusion and exclusion criteria were employed. Eleven articles were deemed to meet the inclusion criteria and were included in the current review. Each was assessed on methodological rigour.
Results: Four areas were elicited from within the literature. 1) Quantitative studies that used the well researched Ward Atmosphere Scale to measure environment and the association with patient satisfaction. 2) Studies that examined the impact of the staff work environment on patient outcomes. 3) Studies that explored qualitatively the impact of the staff-patient relationship on patient experience. 4) Studies that compared standard psychiatric care to therapeutic alternatives.
Conclusions: Findings in the literature revealed that low levels of aggression and a structured and well organised ward where patients feel involved in their care tend to be places where patients are more satisfied. Qualitative studies identified the patient-staff relationship as pivotal in shaping ward atmosphere and the experiences of patients. These relationships were also highlighted as important in mediating the impact of ward rules on patients in that the way rules were enforced by nurses affected patients emotionally. The stressful nature of a poor work environment was also indicated as interfering with staffôs ability to care for patients and consequently patient outcome.
Keywords: *ward; atmosphere; emotional environment; social environment; patient/client; outcome; satisfaction; experience;*
Target Journal: Journal of Applied Psychology

1. Introduction

1.1 Background Introduction

1.1.1The current context of inpatient mental health services

Government policy that has focused on de-institutionalisation and strengthening of community services since the 1980ôs has resulted in a lack of focus on psychiatric inpatient services in terms of service development and research (Johnson et al., 2011). Long standing concerns regarding the quality of inpatient care and patientsôneeds not being met has led to a negative perception of inpatient services, supported by disappointing reports and audits (Healthcare commission (HCC), 2008; Lelliot, 2006). Previous literature has also indicated dissatisfaction from service user groups (e.g. Bowers et al., 2009). This has related to both the physical as well as psychological environment of care for example, a lack of freedom for patients and the use of coercion by staff (Bowers et al., 2009; Wood & Pistrang, 2004**).**

Other aspects of the ward environment for example, high levels of disturbance and aggression have been found to contribute to patients feeling unsafe **(**Wood & Pistrang, 2004). Inadequate amounts of social engagement between patients and staff have also been widely reported and wards have been criticised more generally for lacking a therapeutic culture (HCC, 2008; Lelliott & Quirk, 2004).

Aspirations to improve the social environments of inpatient wards in recent years have informed a variety of new training and service development initiatives, for example ôProtected Engagement Timeô which advises ward staff to ring-fence time on the ward for patient contact only. However, evidence of the effectiveness of theses programmes is lacking (Department of Health, 2002, 2009).

1.1.2 Ward environment and the research context

The environment or general atmosphere of a ward has for a long time been recognised as an important factor in psychiatric inpatient care for patient as well as staff wellbeing. The first large scale study emerged in the late 1960s (Moos & Houts, 1968) and fluctuations in research have been evident since then, reflecting changes in national policy.

Several studies have found that ordered environments with high levels of structure and staff support seem to be associated with higher levels of patient satisfaction (e.g. Timko & Moos, 1998). Another consistent finding is that high levels of aggression and violence, for example from other patients, can lead to individuals feeling unsafe and vulnerable (Jorgensen et al., 2009).

The quality of the patient-staff relationship has been shown to be fundamental to patientsô experiences of the ward environment and to clinical outcomes (e.g. Wing & Brown, 1970). Research has shown that where there is a high level of meaningful therapeutic interaction

between staff and patients, the amount of disturbance, violence and boredom is diminished and patients appear generally more satisfied and engaged with treatment. (e.g. Richmond & Roberson, 1995).Conversely, heavy-handed staff control, for example the use of coercive measures such as restraint, has been reported by some patients as contributing to negative feelings towards staff. A more ócontrollingô approach by staff has also been found to have a negative affect on treatment more generally if it is outside of the context of a positive therapeutic relationship (e.g. Friis, 1986).

Several recent studies have found staff working conditions to be important to patient outcomes and associations have been found between positive working environments, lower levels of staff burn out and higher patient satisfaction (e.g. Kutney-Lee et al., 2009). Equally, feeling unsupported by managers and over stretched due to staff shortages, has been found to be associated with staff reporting increased levels of stress (Totman et al., 2011). These factors can interfere with staffsô ability to care for patients as a lack of support can leave staff feeling emotionally exhausted and without the necessary support to either contain and attend to their own needs or the complex psychological needs of patients (Collins et al., 1985).

1.1.3 Conceptualisations of ward environment and outcome

The concept of ward environment is a difficult one to grasp and in the literature, the terms óward environmentô, ósocial climateô, óward atmosphereô and ótreatment environmentô have been used interchangeably to describe similar things.

The most fully researched instrument for measuring ward environment is the Ward Atmosphere Scale (WAS) (e.g. Caldwell et al., 2006).

The WAS is a self-report questionnaire comprising 100 statements about the ward which are grouped conceptually into three domains; relationships, personal growth and system maintenance (Moos, 1974, 1997). The WAS has been shown to have strong reliability and construct validity (Nesset et al., 2008). It has also been shown to effectively discriminate between different types of hospital programmes (Moos, 1997).

Several studies in the 1960s and 70s examined the association between the WAS and measures of outcome that focused on both symptom relief and improvement in patient functioning (e.g. Alden, 1978). However, it may be problematic to generalise results from these studies to the current inpatient situation as considerable changes have since been made in terms of treatment practices, culture and length of stay and there is also a larger proportion of detained patients in today's wards (Alexander & Bowers, 2004).

More recent studies have relied upon patient satisfaction as their main form of measurement. This has been shown in several papers to be strongly associated with certain subscales of the WAS, specifically those describing a sense of order to the environment and high levels of staff support (e.g. Eklund & Hansson, 1997). However, these studies have been limited by small sample sizes and samples that are unrepresentative of the group of patients being studied. The self report questionnaire is also limited more generally in

terms of what can and cannot be captured about patient outcome and the ward environment.

A smaller number of qualitative studies have been important in exploring patientsô subjective experiences and emotional reactions to different aspects of the environment, for example aggression, ward rules, safety and relationships with staff.

Given the multitude of factors that make up a ward environment, including things that can be more easily quantified, such as number of aggressive incidences, as well as more qualitative features, such as aspects of the staff-patient relationship, there are serious complexities in measuring the concept of the ward environment. For this reason a mixed methods review was decided upon in order to capture the wide scale impact of the environment as well as individual responses to different aspects of environment and how these contribute to outcome.

1.2 Aim of the review

The aim is to provide an up-to-date overview of the findings pertaining to the relationship between ward environment and patient outcomes. A broad definition of ward environment will be adopted to refer to not only the factors identified by Moos (1974) in the WAS but also aspects of the emotional environment including relationships, staff working environment and characteristics of the ward more generally as highlighted by patients.

2. Method

A systematic review of the literature looking at ward environment and the association with patient outcomes was conducted using the main electronic databases (Psych-Info, Scopus, Medline and Web of Science). The key search terms and strings entered into each database can be found in Appendix B. Additional articles were identified from previous reviews and from a search of reference sections of relevant articles. Hand searching of journals was kept to a minimum, as the research in this area is published in a large number of journals.

2.1 Inclusion criteria and search results

Studies specifically exploring ward atmosphere and the impact of this on patients in psychiatric inpatient settings were prioritised as relevant to the current study. These were largely quantitative in nature. However a number of relevant qualitative papers were also included on the basis that they looked at the context of patientsô experiences of the ward environment. Inpatient mental health settings in the context of this review included a range of both forensic and non-forensic settings. Studies were excluded if they explored the ward environment only and did not look at how it related to patient outcomes. Studies were also excluded if they looked at the environment of a general hospital setting or if they explored the impact of the environment on staff. A substantial proportion of relevant research had been carried out abroad and published in international journals. In order to prevent overlap of previous reviews and keep the present review as contemporary as possible, the current

paper included research published from 2000-2012 only. The studies were also required to be published within a peer reviewed journal and in the English language.

The search identified 201 papers. The abstracts were examined on the basis of the inclusion-exclusion criteria and from this 26 full papers were retrieved. All these articles were screened using a data extraction tool and at this point a further 15 articles were excluded due to relevance (see appendix C). 11 articles were deemed to meet the selection criteria and were included in the review. Information regarding the specific methodological characteristics of the studies can be found in appendix D.

3.Results

3.1 Overview of findings from studies using the Ward Atmosphere Scale (WAS)

3.1.1 Information about the WAS

A brief description of the 10 subscales and 3 dimensions that make up the WAS is shown in table 1. Respondents are asked to rate a series of 100 statements relating to these subscales about the ward as true or false.

The WAS-R is a revised version of the WAS, comprising 82 items rather than 100. It has improved psychometric properties and factor structure; that is the factors and

characteristics of factors within each domain have improved validity (Rossberg & Friis, 2003).

Table 1. Description of WAS subscales (Moos, 1974, 1996)

Subscale	**Description**
Relationship dimension	How active patients are in the programme
1. Involvement	Support from staff and also between patients themselves
2. Support	How much open expression of feelings is encouraged
3.Spontaneity	
Personal growth dimension	How independent patients are in decision making.
4. Autonomy	Practical skills and preparation for discharge
5. Practical orientation	Extent to which patients seek to understand their problems
6. Personal problem orientation	Extent of arguing and anger and how this is managed
7. Anger and aggression	
System maintenance dimension	
8. Order and organization	Importance of order and organisation
9. Programme clarity	How explicit rules and procedures are Extent to which measures of control are used
10.Staff control	

Rossberg et al. (2006) examined in a longitudinal study the extent to which different subscales of the WAS-R were related to patient satisfaction. A total of 129 patients completed the WAS-R and three items concerning general satisfaction with the ward at 11 time points between 1981 and 2000. Results revealed changes in the ward atmosphere to be associated with changes in patient satisfaction for six subscales; Involvement, Support, Practical orientation, Order and organization, Angry and aggressive behaviour and Staff control.

Patients indicated a preference for an ordered environment, characterised by high levels of involvement and staff support. Reduced levels of anger and aggression and limited use of measures of control by staff were also seen as important, as well as an emphasis on practical skills and preparation for discharge.

This was a well-planned study covering a twenty year time period with a large sample size, which meant the findings had good reliability. However generalisability was limited due to the inclusion of only one ward. In addition there was a lack of information about patient characteristics so it is not known if the study sample was representative of the ward in general. Although ógroughly 70% of patients were psychoticô (p.177), there was no information about illness severity which means that bias in patientsô responses to the questionnaires due to psychotic perceptions or individual differences cannot be ruled out.

Middleboe et al. (2001) used the WAS to investigate the relationship between patientsô perceptions of the real and ideal ward atmosphere and their level of satisfaction.

101 patients filled in the WAS-R as well as a corresponding óidealô version (WAS-I), which captured their wishes as to the ideal environment according to the same questions. Patients also completed a five item satisfaction scale. This demonstrated acceptable internal consistency.

Results indicated an association between ward atmosphere and satisfaction in that high levels of staff support and order and organisation were shown to predict satisfaction most strongly. Patients rated the ideal ward environment significantly higher than the real ward environment and this also correlated with levels of satisfaction.

Representative sampling was not achieved in this study as patients who were acutely disturbed or who had significant dementia were excluded. Note was made of patients who had signs of hallucinations, delusions, thought disorder or bizarre behaviour by the time of filling in the questionnaires, which increased the validity of results. However, a major limitation was that some patients were assisted by staff to fill in the forms, which may have bias results by leading to an overly positive picture of the ward.

A study by Nesset et al. (2008) examined the impact of 3 weeks of staff training on the ward environment in a forensic psychiatric hospital in Norway using the WAS. Training focused on milieu therapy and aimed to raise the nursing staffôs awareness of the ward environment and its impact on the patients.

Results showed that patientsô perceptions about the environment improved after staff training with patients reporting more order and organisation to the environment, a higher level of staff support, less aggression and a feeling of being more involved in their treatment. In parallel there was an increase in patient satisfaction post training.

Limitations of this study included the fact that only a small number of patients participated from one psychiatric department, which seriously compromised generalisability. Information collected about patients showed the study sample to be generally representative of patients on the ward in terms of age, gender, length of stay and diagnosis. However information about illness severity would have been helpful to see if generally better functioning patients made up the study sample as has been the case in previous studies (e.g. Middleboe et al., 2001).

The authors were unable to control for changes to the ward other than staff training, during the period of study therefore firm conclusions about the causes of improvement in patient satisfaction could not be drawn.

A more in-depth study by Jorgensen et al., (2009) looked at the association between ward atmosphere and different measures of patient outcome, including patient satisfaction, in three different psychiatric wards.

Eighty patients responded to a set of questionnaires at admission and discharge which comprised the WAS-R (Rossberg & Friis, 2003), the five item Good Milieu index, (Moos,

1974) and three measures of outcome: the symptom checklist SCL-90R (Derogatis, 1992), the Generalized Self-Efficacy Scale (GSE) to measure general functioning and a seven item index about life satisfaction. Reliability testing showed all questionnaires to be acceptably reliable.

Significant correlations were found between wards in terms of ward atmosphere and patient satisfaction. Consistent with previous findings, the more ordered, organised environments where patients were involved in the programme and helped with practical skills and preparation for discharge were associated with higher levels of patient satisfaction. No significant associations were found for any of the outcome measures expect for one index on the symptom reduction checklist, where the patients on the wards associated with better environments, showed a reduction in symptoms.

A major limitation of this study was that only 39% of patients considered eligible for the study participated and an additional number of patients were excluded because they were considered unable to consent or had been admitted for less than a week. A comparison analysis revealed that the study sample had slightly fewer patients with psychotic disorders than on the wards which, reduced reliability. Ability to generalise results was also reduced as the study sample was small and the characteristics of patients in the sample were unlikely to be the same as patients on other wards.

It is commendable that the authors attempted to examine patient outcome, where other studies have relied upon satisfaction as their main dependent variable. However,

administration of outcome measures post discharge would have strengthened this study as some aspects of outcome, for example changes in patient functioning and general life satisfaction, may have become apparent once patients were living independently back in their own homes.

3.1.2 Conclusions from studies using the WAS

All Studies in this group using the WAS found ward atmosphere to be associated with patient satisfaction. Consistently, ordered environments, with high levels of involvement and staff support and reduced levels of anger and aggression were shown to predict patient satisfaction most strongly. However the generalisability of findings in this group was limited due to small sample sizes and in most cases representative sampling was not achieved (Rossberg et al., 2006; Middleboe et al., 2001; Nesset et al., 2008; Jorgensen et al., 2009). This reflects a more general limitation of quantitative research on psychiatric inpatient wards where inevitably some patients will be too unwell to participate.

Measures of patient satisfaction used by studies in this group were brief (5 items) and appeared to lack depth. In most cases, the psychometric properties were not discussed and may have been limited; in which case reduced validity of results should be considered (Rossberg et al., 2006; Middleboe et al., 2001; Nesset et al., 2008). The inclusion of qualitative data from patients for example, open ended questions in questionnaires or interviews would have been useful to aid understanding of the statistical associations found between ward atmosphere and satisfaction. Only one study in the current group examined

patient outcome and found no significant associations with ward environment (Jorgensen et al., 2009). It was postulated that an indirect relationship may exist between ward environment and treatment outcome given the thinking that patient satisfaction is a good indicator of quality of care. However more research is needed to understand this relationship further (Jorgensen et al., 2009).

3.2 Overview of findings from studies examining the impact of the staff work environment

In a 10 year longitudinal study between 1990 and 2000, Rossberg and Friis (2004) examined the influence of the ward atmosphere as well as staff working conditions on patient satisfaction. Four hundred and forty two inpatients and 640 staff members from 42 different psychiatric wards completed the WAS (Moss, 1974), as well as three questions developed by Moos (1989) to capture general satisfaction. Staff also completed the Working Environment Scale (WES-10) to measure staff working conditions (Rossberg et al., 2004).

Patient satisfaction was found to be strongly correlated with their perception of the ward atmosphere. However, contrary to previous research, patient satisfaction was not correlated with staff working conditions. This may have been because the study took place primarily on short stay wards where there was reduced opportunity for staff working conditions to make an impact on patients.

The sample was large in this study and spanned a 10 year time period which added to the reliability of results. However, there were limitations. No information was collected about participants in terms of age, gender, diagnosis or illness severity, so it is not possible to say if the sample was representative. The response rate was not stated, but it may have been the case that more severely disturbed patients refused or were unable to participate, as has been the case with much inpatient research.

The WES-10 was shown to have good psychometric properties, but the satisfaction scale lacked reliability testing and may have been too brief to capture patientsô feelings about satisfaction towards different aspects of the ward and quality of care received. Qualitative data from both clinicians as well as patients about the work environment would have strengthened this study.

Rossberg et al. (2008) also studied ward environment, patient satisfaction, and staff working conditions, between 1981 and 2000. One hundred and twenty nine patients from one acute psychiatric unit completed the modified WAS-R and 359 staff members (mostly nurses) completed the WES-10. Both patients and staff also responded to three questions concerning general satisfaction.

Results revealed a significant correlation between patient satisfaction and staff working conditions, particularly for the WES-10 subscale of óself-realisationô. This correlation showed patients were more satisfied when staff felt supported and able to use their professional knowledge working on the ward.

This indication that staff working conditions are important for how happy patients are with their care contrasts with the findings described above by Rossberg and Friis (2004). This may be because Rossberg and Friis (2004) examined 42 different wards whereas the current study examined only one ward, which may have eliminated the influence of other variables on patient satisfaction to do with differences between wards such as type of treatment offered.

3.3 Overview of findings exploring the impact of the staff- patient relationship

Gilbert et al. (2008**)** undertook a user-led study which researched patient outcome qualitatively. Nineteen service users took part who had together had inpatient stays in over 10 different hospitals in England. They each participated in unstructured interviews which opened with the request: "Tell me about your experiences of being an inpatient".

The main finding was that when participants talked about their experiences of hospital, they did so largely within the context of a relationship and thematic analysis revealed that five of the eight main themes referred to aspects of relationships, mainly with staff. The theme óCommunicationô for example, described instances of poor communication with staff which could make patients feel angry or patronised. On the other hand, positive experiences of feeling listened to and understood could lead to patients feeling cared for and respected.

The theme ôSafetyô revealed that violence or aggression from other patients could create an atmosphere of fear on the ward and some participants spoke about staff being instrumental in provoking situations that could make aggression from other patients more likely, for example, ówinding them upô and óplaying gamesô (p. 5). Conversely regular interaction with staff could instil a sense of safety in patients. ôTrustô within a relationship was described as important in providing a positive experience of being in hospital, whereas mistrust, frequently linked with coercive encounters with staff, contributed to a negative experience.

The lack of a standardised way of measuring patient outcome limited this study, however, aspects of outcome, (e.g. feeling safe and cared for or feeling unsafe and mistrusting of staff) were discussed individually by participants. The lack of a standardised way of capturing patientsô perceptions of the ward environment could be said to be a further limitation, however the rich, in depth personal descriptions given by participants about the emotional environment, including aspects of the staff-patient relationship, were arguably more meaningful than standardised measures.

The analysis in this study was undertaken with rigor and reported in an open and transparent manner. The use of member checking contributed to the strength of the evidence.

Both interviewers in the current study had had previous experience of admission to a psychiatric ward. This may have been an advantage in terms of data collection as it may

have engaged interviewees to talk about experiences they may not have wished to share with professionals. However, the authorsô own experiences of hospital admission may have sensitised them to certain themes and concepts in the analysis. A more thorough description of the authorsô reflective process would have been valuable along with the use of peer review of themes in reducing the potential for researcher bias.

Bressington et al. (2011) looked at service user satisfaction in forensic settings and how this related to ward environment as well as the therapeutic relationship between service users and their key-workers.

Satisfaction was measured using the Forensic Satisfaction Scale (FSS) and ward environment was measured using the 'Essen Climate Evaluation Schema' (EssenCES), (Schalast et al., 2008), which was reported to have concurrent validity with the WAS (Moos, 1974). The therapeutic relationship was assessed using the Helping Alliances Scale (HAS), which asked participants about whether they felt respected and understood by staff and whether they felt they were receiving the right treatment (Priebe & Gruyters, 1993). All measures were reported to have good reliability and validity. Forty four service users from seven different secure settings took part.

In line with previous research, associations were found between participantsô level of satisfaction and the social environment. Interestingly however, a stronger association was found between satisfaction and perception of the therapeutic relationship, in that service users who were more positive about the therapeutic relationship were more satisfied

generally with services. Evidence of the role of both the social environment as well as the nurse-patient relationship was provided in relation to how happy service users were with their stay.

A comparison of demographic information about participants (age, gender, ethnicity and length of inpatient stay) with a benchmarking survey (Bartlett, 2006; cited in Bressington et al., 2011) showed the study sample to be ôbroadly reflective of the overall forensic patient population in Londonô (p.1352). Additionally, none of the demographic characteristics were found to be significantly associated with satisfaction, which added to the validity of the concepts of ósocial environmentô and ótherapeutic relationshipô as stand alone factors associated with satisfaction. However, only 40% of service users consented to take part and these may have been patients with a more positive view of services, which would have inflated satisfaction levels in the results.

Using a mixed method approach, Alexander (2006) investigated the ward rules of two acute psychiatric wards and the impact of these on patient outcomes. Outcome was explored qualitatively with the use of semi structured interviews in which 30 patients took part. Ward environment was measured using the WAS (Moos, 1974) and patientsô beliefs about ward rules was captured using the Hospital-Hostel Practices Profile (Wykes, 1982).

Quantitative results showed a difference between wards in terms of their rules and also showed that ward rules were associated with ward environment on the WAS. Specifically

the ward with more rule breaking was associated with higher levels of anger and aggression.

Qualitative results revealed six themes (coercion, distress, confinement, acceptance, humiliation and anger), which described the impact of the rules on patientsô experiences. Particularly interesting was the theme ódistressô, which highlighted patientsô emotional reaction to some of the rules, for example the smoking ban. Distress also described patientsô response to the way they were spoken to by nurses and reprimanded when rules were broken. Additionally, distress stemmed from the perception that nurses were emotionally unavailable because of their duty to enforce the rules.

The theme óAcceptanceô described patientsô reactions to accepting the rules which included feelings of boredom and loneliness as well as concern about a loss of autonomy. Some patients felt anger towards the ward rules which made them want to escape.

Ward rules in this study were shown to be integral to the ward environment and were shown to impact significantly on patientsô experiences. Consistent with other studies in this group, the role of the nurse-patient relationship was highlighted as significant. In this case the nurse-patient relationship was pivotal in mediating patientsô reactions to the ward rules. The way staff enforced the rules and then responded to patients when rules were broken for example, made a difference to how patients felt. The predominately negative reports from patients led the authors to suggest a lack of therapeutic context for rule enforcement.

Like other studies in this group, a lack of a standardised way of measuring patient outcome could be seen as a limitation although subjective views expressed by participants about outcome were authentic and illuminating. There was a lack of explanation of how the author developed themes in the current study which limited results in terms of the potential influence of researcher bias.

3.4 Overview of findings from the 'Alternatives study' comparing standard psychiatric hospitals with alternatives

The following two studies form part of the larger óAlternatives Studyô, which compared residential alternatives, such as voluntary run crisis houses, crisis team beds, non-clinical alternatives and general therapeutic wards, to standard acute psychiatric wards in England.

Osborn et al. (2010) compared patient satisfaction and ward environment in four standard psychiatric services and four residential alternative services.

A total of 314 patients filled in the WAS, two questionnaires regarding satisfaction (Client Satisfaction Questionnaire and the Service Satisfaction Scale ï Residential form) and a questionnaire about the experience of admission (Admission Experience Scale, Gardner et al., 1993). Psychometric properties were not discussed.

Results from the WAS and Admission Experience Scale revealed that patients favoured alternative services in terms of their environment, because they were perceived to have lower levels of disturbance and less anger and aggression. Patients also perceived greater autonomy, more support from staff and fewer experiences of coercion in these environments. In parallel, significantly greater levels of satisfaction for the alternative services were revealed on both questionnaires. Results did show however that differences in populations between services, namely the smaller numbers of people detained under the Mental Health Act in the alternative services, accounted for some of the statistical difference in satisfaction. It is possible that differences in patient diagnosis, may also have accounted for some of difference in satisfaction between services although this was not examined.

This was a national study with a large sample, which explored residential alternatives to psychiatric care, an area that little recent research has explored. However due to the variability of alternative services results may not be generalisable. Like previous research in this area (e.g. Middleboe, 2001), a large number of patients were excluded as they were deemed too unwell which meant the sample was not representative. Furthermore, patients in this study completed questionnaires near to discharge which may have lead to a more positive perception of the ward environment.

In a qualitative part of the óAlternatives Studyô, Gilburt et al. (2010) compared patientsô subjective experiences of traditional psychiatric and residential alternative wards. Forty patients took part who had all had experience of in-patient stays on both traditional wards

as well as those classed as alternatives. It was not the aim of this study to investigate patient outcome, however aspects of outcome were indicated in patientsô responses to in-depth interviews which asked them to talk about their hospital experiences.

Thematic analysis revealed several themes relating to the impact of aspects of the environment on patient experience. The two themes óenvironmentô and ópinion about servicesô for example, revealed an overall patient preference for the environment of alternative services. This was because they were perceived as safer, with lower levels of disturbance, more opportunity for positive interaction with staff and less coercion. Interestingly, the physical environment of either type of service was not identified as being as important as the staff and other patients who were viewed as integral to the making of an atmosphere. Almost half of patients referred to the idea that ópeople make a placeô (p.27).

óRelationshipsô was by far the biggest theme and most important factor in defining patientsô experiences. Patients talked of the value of staff being, caring, friendly, polite and genuine. They also said they had felt threatened within relationships with staff who were experienced as not listening or caring. One patient said: ôI felt the whole environment was very, very threatening . . . the nurses refusing to listen or understand.ô (p.28).

The process of analysis in the current study appeared to be thorough and included peer review. Results supported findings from the quantitative study described above in that patients reported being happier in the environments where there were lower levels of

disturbance, where they felt safer and experienced less coercion from staff and more positive interaction. The most striking finding from the current study was the significance of relationships on patient experience.

It is worth noting that results in the current study may have been influenced by the fact that patients were interviewed while residing at an alternative service and therefore also relied upon retrospective recollection of their experiences of traditional hospital services which have been subject to other influences. Some of the negative accounts of environments in traditional hospitals may have been accounted for by the larger number of patients on these wards at the acute end of an illness, although this was not explored. It is also likely that patients in alternative services elsewhere will have had different experiences which should be considered when interpreting results.

4. Discussion

The current paper aimed to review the recent literature pertaining to the association between ward environment and patient outcome. Four areas were elicited from within the literature, which were grouped accordingly: studies that used the WAS; studies that examined the impact of the staff work environment; studies that explored the impact of staff-patient relationships and studies that compared standard psychiatric care to therapeutic alternatives.

Studies using the WAS provided evidence of aspects of the ward environment associated with higher levels of patient satisfaction. These related to adequate staff support, low levels of aggression, a structured and well organised ward and an environment where patients feel involved in their care and helped with practical skills. Studies also informed of the wide scale impact of this in different hospitals nationally. However, studies in this group were limited in generally reflecting the views of better functioning patients as mostly those who were excluded were the more severely disturbed patients. A further major limitation of studies in this group was that all but one of them relied upon ratings of patient satisfaction.

Measuring outcome and assessing change is a challenge in all areas of mental health but is particularly difficult for inpatient settings where the psychology of the client group is the most complex and where people commonly present with multiple difficulties. The brief ratings of satisfaction used by studies in the current review severely limited findings as they were unable to investigate associations that might exist between ward environment

and aspects of patient outcome, for example changes in functioning or symptom reduction. Furthermore, patient satisfaction can be influenced by personal attitudes, and past experiences and as research has shown patients can express satisfaction despite the reporting of a number of unpleasant experiences (Williams & Wilkinson, 1995).

The question of timing and when you measure satisfaction or outcome is also important. Studies in this review administered questionnaires at admission and discharge. However, certain outcomes, for example symptom reduction and changes in functioning may only become apparent once a patient leaves hospital. Future research using the WAS would benefit from administering questionnaires after discharge as well as at multiple time-points during admission to assess predictors of change in satisfaction and outcome, according to different environmental influences.

The one study that utilised outcome measures in the current review, provided evidence of an association between patient satisfaction, ward environment and outcome in terms of symptom reduction, but not for general functioning or perceived quality of life (Jorgensen et al., 2009). A recent systematic review concluded that patient satisfaction had a significant, though small, effect on outcome (Preference Collaborative Review Group, 2008). The relationship between patient satisfaction and outcome therefore is unclear and needs further research.

Three studies in the current review adopted a qualitative approach and most striking from these was that all studies identified the patient-staff relationship as pivotal in shaping ward

atmosphere and the experiences of patients. Gilburt et al. (2008) for example, described aspects of the patient-staff relationship which contributed to patients feeling safe and at other times angry and disempowered. Gilburt et al. (2010) also described patientsô preference for environments where there was more positive interaction with staff and where staff were perceived to be more available generally.

The importance of staff-patient contact is recognised in government recommendations (Department of Health, 2006). However indicated in this review is that it is not just staff contact but the quality of the relationship that is important. This was reported by Bressington et al. (2011) who found that service users who had a more positive therapeutic relationship with their key workers were more satisfied generally with treatment, which is consistent with previous findings. Leach (2005) for example, found that a strong therapeutic relationship can be an agent for change in itself and can be a strong influence on patient outcome (Leach, 2005).

Qualitative studies in this group were limited by small samples sizes and a limited ability to generalise, although the fact that they were consistent in what they found (e.g. the importance of the patient-staff relationship) improved the strength of evidence. Studies in this group were also consistent with previous findings (e.g. Leach, 2005). The lack of a standardised way of measuring outcome and ward environment is important to acknowledge, however the rich descriptions given by participants about aspects of the ward environment and the impact of these on their experiences was meaningful. Studies in

this group enhanced understanding of some of the aspects of environment identified as important by studies using the WAS (e.g. safety, support from staff and feeling involved).

Alexander (2006) highlighted the impact of ward rules on patients and how rules were enforced by nurses which was reported by patients to impact on them emotionally. Results showed patientsô felt distressed by the perception that nurses were emotionally inaccessible because of their duty to enforce the rules. Psychodynamic theory draws a parallel between staff on inpatient wards and the function of parenting suggesting that clear rules can act as containing boundaries which provide a corrective emotional experience for patients who may have had previous experiences of poor parenting (Chrichton, 1998; Kologjera et al., 1989). Given findings in the current review the point made by Crichton (1998) is important; that staff need to be helped to enforce rules in a compassionate rather than punitive way in order that patients feel safe and connected with staff rather than distressed and alienated.

The more rigorous study looking at working conditions by Rossberg et al. (2006) indicated that the stressful nature of a poor work environment can influence staffs ability to care for patients. This is consistent with findings from previous psychodynamic ward observation studies, which have indicated the stress and anxieties inherent for staff working in psychiatric inpatient settings and the defensive ways of working (e.g. withdrawing from patients emotionally) staff may unconsciously employ in order to manage the strong mixed and potentially disturbing feelings that can be evoked by their task. This provides further

understanding of how a stressful work environment can interfere with staffsô ability to care for patients (e.g. Menzies Lyth, 1979; Megens & Van Meijel, 2006).

Continuing research on staff working conditions is particularly relevant, given recent changes to the Health and Social Care Bill (2012) and the fact that staff face changes to the way there are expected to work as well as some uncertainty over working conditions in the next few years. The impact of these changes on patients will be important to monitor.

4.1. Clinical Implications

Implementing well organised ward routines and procedures, and attending to the structure of a hospital programmes would be recommended in order to create a more preferable environment for patients (Totman, 2011).

This review also suggests that current government initiatives that are highly focused on staff-patient interactions may have the potential to improve the social environmentsô of wards and patient satisfaction. However, for these to be effectively implemented, it is important that staff feel able to dedicate time to individual patients (Totman, 2011). They also need to feel supported themselves as highlighted in this review was the impact on patientsô of the stressful nature of staffs working conditions. Opportunities for staff to have more high quality interactions with one another may have a function in reducing stress however support for staff is also required in relation to supervision and reflective practice that can provide containment and a space to deal with stress (Flood et al., 2006;

Brennan et al., 2006). Emphasised in this review was the importance of staff developing effective therapeutic relationships with patients in order to maintain an environment where patients feel safe, supported, involved and emotionally connected to staff. These containing relationships are also important given the high levels of disturbance and aggression reported on wards and the negative impact of this on patient satisfaction.

However balancing the therapeutic aspects of their role with the custodial parts of their role as rule enforcers is a challenge for staff, as was highlighted. Training and support is needed to enable staff to negotiate these roles so that the rule enforcer role does not leave patients feeling distressed (Tarrier et al., 1999).

4.1.1. Limits of the review.

This review examined key areas of the literature from 2000 that explored the impact of ward environment on patient outcome. However, limitations of the review included search terms used to find relevant articles, which may not have been broad enough to retrieve all the relevant literature. Inclusion criteria may also have excluded papers that may have demonstrated important findings. In addition, there may be a number of outcome measures which have not yet been related to ward environment which would mean that the relationship between ward environment and patient outcome may be more complicated than the present review suggests. Constraints within the questionnaire method in terms of using quantitative methods to assess qualitative experiences such as relationships may have limited findings although qualitative studies in the current review illuminated aspects of

ward environment which were important subjectively for patients. To further explore the impact of ward environment on patient outcome other techniques such as focus groups conducted post discharge could be investigated.

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Section C

A qualitative exploration of staff responses to a formulation based upon a psychodynamic ward observation study

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By

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Doctorate in Clinical Psychology

Research Report Abstract

Purpose: The research explored staff responses to the findings of a psychodynamic ward observation study. The aim was to provide an initial means of evaluating the observation method. **Method:** 22 members of staff (11 on day one and 11 on day two) attended two away days where they learnt and participated in discussion about a formulation that had been developed from a psychodynamic observation study of their ward. The days were audio recorded and the researcher also attended and took observation notes. Data was analysed using thematic analysis. **Results:** Six main themes were developed to describe the different responses staff had. Certain feelings, experiences and behaviours expressed by staff during both days were understood to be in accordance with the formulation. Other discussions namely regarding management practices were not found to be reflected in the formulation and were considered potentially helpful for re-formulation. Staff were found to engage selectively with material in the formulation. A sense that staff valued the opportunity to share difficulties and be contained by the facilitator came across strongly. **Conclusions:** It was hypothesised that parts of the formulation were more palatable to staff than others which may have been more anxiety provoking and that this may explain the dynamic nature of staffsô engagement during the away days. It was considered significant that the formulation was delivered by a facilitator with whom staff had an established supervisory relationship, which may have enabled staff to feel safe enough to explore ideas. That findings provided some preliminary evidence of the validity of the psychodynamic observation method was discussed as were ideas about possible limitations to the method as highlighted by the current study.

1.Introduction

1.1 Background

1.1.1 The psychoanalytic observational method

Over the last 50 years a body of research has emerged using the psychodynamic method of observation. This attempts to explore an organisationôs culture and unconscious ethos, to try to understand how it works, how tasks are carried out and whether or not work practices, help or hinder staff in completing their task.

The observational method was originally pioneered by Bick (1964) not as a research method, but rather a training exercise for child psychotherapists to make observations of mother-infant interactions and learn about child development, (Bick, 1964; cited in Hinshelwood, 2000). It was later adapted by Hinshelwood for the training of psychiatrists and psychotherapists to observe and seek to understand mental health organisations such as psychiatric wards (see Hinshelwood & Skogstad, 2000 for a more detailed account).

Typically, the method relies on a researcher visiting an organisation weekly over three months, making hourly observations at specific arranged times (usually at the same time of day) to gather information about how the organisation works.

The observerôs role is to observe events that happen while at the same time attending to the emotional atmosphere of the organisation as well as their own personal, subjective experience; for example, feelings towards events such as, approval or disapproval, like or dislike and an urge to engage, or become involved in what is going on. Notes relating to these things are written down by observer after the observational hour (Hinshelwood & Skogstad, 2000).

The method is based on the idea that much of the observerôs experience during observation will occur outside of conscious awareness and that thoughts may be noted down without full conscious appreciation of what they mean. However, the observerôs thoughts are considered important no matter how irrelevant they seem, as they may reflect unconscious processes within the organisation. In this sense, evidence collected in this method is evidence of the conscious as well as unconscious experience of being in an organisation.

A seminar group, which the observer attends weekly, is set up to support the researcher in becoming more conscious of and then interpreting observations. Possible meanings are considered in terms of psychoanalytic theory.

Some researchers have used the observation method to observe general hospital settings and several have used it to explore the environments of acute psychiatric inpatient wards.

1.1.2 Acute Inpatient care

Concerns about the poor quality of psychiatric inpatient care are long-standing and it has been suggested that with a focus on developing community services over the last twenty years, inpatient services have not received the money, resources and service development required (Lelliott, 2006; Healthcare Commission, 2008). Difficulties such as inadequate amounts of staff- patient contact, as well as high levels of aggression and violence on wards and the use of coercive measures by staff have been widely reported.

Furthermore, a focus on cost effectiveness and efficiency within the NHS as well as recent increased pressure to find savings has meant increased pressure on staff and service managers (Obholzer & Roberts, 1994). Previous literature has indicated for example, that staff feel service managers are more concerned with cost and turnover rather than care which puts nurses under pressure to move patients on quickly and constricts the amount of time staff can spend with patients (Austin, 2009; Lelliott & Quirk, 2004; Totman, 2011).

Inevitably there is a high amount of stress attached to the environment of a psychiatric ward, which is relevant to those working within them as well as those receiving care. Reports of service users and staff membersô experiences of inpatient wards have illustrated a high level of criticism and dissatisfaction with the physical as well as psychological environment of care (DoH, 2002; Wood & Pistrang, 2004).

1.1.3 Ward atmosphere

Research supports the idea that ward atmosphere or environment is important for the psychological wellbeing of staff as well as patients. Much of the research in this area relies on the use of quantitative questionnaires such as the Ward Atmosphere Scale: a 100 item rating scale (WAS: Moos & Houts, 1968). Studies using the WAS have found that ordered environments, with high levels of involvement and staff support and reduced levels of anger and aggression are associated with higher levels of patient satisfaction (e.g. Rossberg et al., 2006).

1.2 Psychodynamic observation studies

Limitations with quantitative measures relate to the depth and range of what can be captured about a ward as research is confined to the constructs and potential limits of the measure adopted. The psychoanalytic method of observation, arguably, offers a more flexible approach and permits a more in-depth exploration of the ward environment and the impact of the stresses on those operating and being cared for. Observation studies have furthered understanding about ways in which organisations such as hospital wards work to manage and protect workers from pressures and stresses.

Menzies Lyth (1960) for example, produced a seminal paper exploring the stresses and coping mechanisms of nurses working in a large general hospital. She described the organisational defensive structures that protected nurses from becoming overwhelmed with

awareness of the anxieties and emotions that may have been provoked in their day to day work, for example, the anxiety of being in close contact with death and illness. Other researchers have observed mental health organisations. Donati (1989; cited in Hinshelwood, 2000) for example, observed a chronic psychiatric ward and noted a particular style to the way staff related to patients which he described as ótouch and goô meaning contact was brief and avoided ongoing dialogue. This was interpreted as a form of emotional distancing which was understood as relating to a basic pervasive fear of madness in workers and of getting too close to patients and the madness. Goodwin and Gore (2000) replicated this study in a complex mental health inpatient setting and also observed nurses behaving in ways that were inconsistent with the primary task of the ward (rehabilitation of patients). This was understood as a means of defending themselves from anxieties evoked from their work, such as fear of madness, loss of control, a feeling of responsibility for the vulnerability of patients and a sense of failure or despair at the chronicity of the clientsô difficulties. Other studies have reported similar findings and ideas about anxieties inherent within mental health setting (e.g. Rees, 1987; cited in Hinshelwood, 2000).

1.3 Criticisms of the method

One of the criticisms of the psychodynamic method of observation is that visiting a ward for an hour over six weeks is not representative of what actually happens. A further criticism is that the approach relies heavily upon the researcherôs subjective experiences and responses, which could be based largely on the researcherôs personal beliefs**.** Masson (1988) argues that in psychotherapy therapists cannot hear what a client is really saying because they are blinkered by their own view of reality. Therefore psychotherapy works to impose the therapist's views on the patient and as a consequence misrepresents their reality. The same argument could be levelled at the observation method; that is, that the observer could be imposing their own perception of reality onto environments based on previous personal experiences.

Related to this, the method has been criticised for its reliance on psychodynamic theory for explaining and interpreting observations which could render it un ï falsifiable (Popper, 1959). This relates to the perception that if observations are not accepted as accurate it is assumed that the reader is being defensive. This makes it hard to have any real objections to observations and hard to test claims about unconscious anxieties for example, are they real or just something the felt by the observer.

1.4 Consultation and feedback to staff

Sharing the findings from a psychodynamic observational study with staff on the ward could be a good first step in testing some of the above criticisms and evaluating the method. Discussing the findings with staff for example, would give them an opportunity to talk about whether what was observed resonates with their experience of being on the ward. It would also be an opportunity for triangulation and to learn about aspects of a wardôs culture or practice that may not have been picked up on by the observer.

The process of feedback also has the potential to help staff further develop awareness of the anxieties and pressures present in their day to day work and how these are managed, as well as the consequences of acting upon these pressures unconsciously and automatically.

Given the original training context out of which the psychoanalytic method of observation first developed, feedback of observations to participants has not been addressed in the studies previously described, but rather findings have been used for the purposes of the researchersô professional training only.

1.5 The Research Questions

The rationale for exploring the process of feedback to staff was for an initial evaluation of the psychodynamic method of observation.

The primary aim was:

> To explore and qualitatively analyse staff responses to a formulation based on a psychodynamic ward observation study.

2. Method of Enquiry adopted

2.1 The context for the wider study

The current study forms the second in a series of studies. First in the series was a psychodynamic ward observation study. The aim of current study was to analyse staff responses to hearing about a formulation based on findings from the above mentioned observation study. This was for an initial evaluation of the psychodynamic observation method.

2.1.1 The previous psychodynamic observation study

The current study builds on a psychodynamic ward observation study undertaken by a Clinical Psychology Trainee for her thesis. This project set out to explore the culture of an acute inpatient ward and learn about ward life and the social environment. A series of six hour-long observations were made over two months where the researcher attended and afterwards took notes about the general atmosphere, the nature of emotional relationships between people she observed and the emotional impact of the ward on her. Notes were written up and then discussed within seven supervision group sessions to analyse the observation material. Thematic analysis (Braun & Clarke, 2006) was conducted on the observational data and supervision group data and five main themes emerged which were used to describe the ward culture from the observerôs experience. See appendix E for a list of the main themes and sub themes.

2.2 Planning the away days

Two away days were organised by the Ward Manager and Clinical Psychologist attached to the ward, for staff to learn about and discuss ideas from the observation study. These were planned from the start of the observation study and so staff were expecting them. A formulation was developed by the Clinical Psychologist along with the researcher who undertook the observations that was suitable for sharing. The away days were designed to be interactive rather than didactic and the presentation of the formulation was planned in order that it was perceived as a set of ideas about the ward for staff to discuss rather than a ótruthô.

The complexity of feeding back psychoanalytic ideas and the potential for this to be anxiety provoking was borne in mind when planning the away days. The Clinical Psychologist who facilitated the days had worked with the ward over a number of years and through her role facilitating reflective practice groups had an established supervisory and therapeutic relationship with staff. This was considered crucial in providing staff with a safe context within which to hear about what was observed and share their thoughts and feelings.

The Clinical Psychologist planned the structure of the days drawing on Winnicottôs (2005) idea about the timing of an interpretation in individual therapy. Staff were offered a

reflective space to explore ideas about the ward themselves before learning about the formulation.

2.3 Design

The researcher of the current study was interested in exploring the complexity of staff responses and for this reason a qualitative approach was decided upon. The study aimed to take a first step in evaluating the psychodynamic observation method through a thematic analysis of naturalistic data, generated from two away days where a formulation based upon a ward observation study was shared with staff on the ward.

2.4 Choice of method and rationale

Thematic analysis was considered to be the most appropriate method for analysing staff responses during the away days. Thematic analysis offers a flexible approach to analysing qualitative data as unlike other methods it is not strongly attached to any pre-existing theoretical framework and can therefore be used within different theoretical frameworks (Boyatzis, 1998). Thematic analysis can be a realist, constructionist, or ócontextualistô (e.g. critical realism) and as such, can be a procedure that operates to both reflect reality and unpick the surface of órealityô (Braun & Clarke, 2006). It was anticipated that analysis in the current study would do both and thematic analysis offered this flexibility. Thematic analysis is also regarded as a good method for organising and describing patterns in the data in detail, which was valuable given the aim of describing staff responses in depth.

Finally thematic analysis can be used to interpret various aspects of the research topic which meant that analysis in the current study could attempt to not only describe but also understand the different responses staff had to the formulation.

2.5 Context of the study

Staff who attended the away days worked on an acute psychiatric ward which catered for individuals with complex mental health needs as well as some individuals with a forensic history. The ward was located within an NHS trust in an urban area in the Midlands.

Following a number of serious incidents within the Trust, inquests were taking place and a review of all inpatient policies and procedures had been commissioned. Several members of staff on the ward studied also faced disciplinary procedures. The current study took place amid this atmosphere of investigation and watchfulness.

2.6 Procedure

Ethical approval for the current study was sought and obtained from the Leicestershire Research and Development Committee **(**appendix F). Ethical approval from an NHS research ethics committee was not required as the current study involved only staff members as participants.

A pilot thematic analysis was conducted prior to the away days on a set of two interviews with the Clinical Psychologist attached to the ward. Analysis and findings are not presented in the current study. For the away days, ward staff were told that they were expected to attend one of the days, although this was not a mandatory part of their work. Both away days were audio recorded and then transcribed for analysis. The researcher of the current study also attended the away days to observe aspects of staff behaviour that could not be picked up on by the audio recording for example, non verbal aspects of the staffsô response to the formulation. Hollway and Jefferson (2002) state that there are unconscious dynamics that occur in the research setting and that professionals tend to behave as ódefended subjectsôand avoid disclosure of personal opinions and experiences to protect vulnerable aspects of themselves. The timing of the away days, amidst national concern regarding inpatient care and investigations of inpatient services more locally increased the threat to the validity and openness of staff discussions. It was therefore considered valuable for the researcher of the current study to observe staff affect during the day and the emotional atmosphere in the room more generally as a compliment to analysing what staff said in the audio recorded discussions. A chronology of the research process can be found in appendix G

2.7 Participants

The allocated Clinical Psychologist for the ward was thought about as a óparticipant collaboratorôbecause she worked in collaboration with the researcher to organise, plan and facilitate the away days. Having worked with the ward over a number of years, she had an

established supervisory and therapeutic relationship with staff. Three hours a week of her time was allocated for consultation with the ward as part of the Trustôs wider aim of increasing psychological mindedness on inpatient wards. Twenty two members of staff from the ward attended the away days.

2.8 The away days

2.8.1 The structure of the away days

Participant information sheets **(**appendix H) and consent forms (appendix I**)** were made available to staff three weeks in advance of the away days and staff were offered the option of an informal meeting or telephone conversation if further information was required. Consent forms were collected from the ward by the researcher.

The away days were facilitated by the Clinical Psychologist participant collaborator and took place on two consecutive days, in a university building away from the ward. Half of the staff team (11) attended one day and half on the other day (11). The same itinerary was followed each day (see appendix J for full itinerary provided by the facilitator**).**

In the morning the facilitator shared with staff the planned itinerary **(**appendix J**)** and invited staff to share their hopes, expectations and aims for the day. The facilitator then invited staff to discuss the role they had on the ward and share feelings about their work and task. Staff were encouraged to think about the pressures they faced and a couple of

short video clips were played from a sitcom about nurses working in similar environments. Staff were invited to share their responses.

Throughout the morning, the facilitator introduced ideas from psychological theory linked to the formulation to support staff in understanding feelings they had about their work. These included the concept of learned helplessness and psychodynamic ideas about the inherent anxieties attached to working with complex and disturbed patients.

Staff were provided with a complimentary lunch at a local restaurant over one and a half hours planned in order that they could sit and be together as a group and feel nurtured. In the afternoon staff were reminded of the observation study, what it involved and the rationale for conducting the observations. The facilitator then presented the short power point presentation **(**appendix K) containing the formulation and explained ideas. Staff were asked for their responses and thoughts and also if ideas resonated with their experience. In the second half of the afternoon the facilitator invited staff to think about what could be done with the ideas and difficulties discussed in terms of potential changes to practice on the ward. Both away days were audio recorded from start to finish.

A brief evaluation form (appendix L) was given to staff at the end of each day asking for their feedback and giving them space to comment on anything they were unable to share during the day (appendix J).

2.8.2 Observation

The researcher of the current study attended both away days and took observation notes. These focused on staffsô apparent affective response to what was being said, the emotional atmosphere in the room, and feelings the observer was experiencing. The time of each observation was noted.

2.9 Transcribing

Both away days were transcribed by the researcher from start to finish in a way that included each word spoken, pauses, laughs and hesitations in accordance with the procedure described by Braun and Clarke (2006). The researcherôs hand written observation notes were typed up by the researcher and elaborated with some reflective comments immediately after both days. These notes were then typed into the transcripts of staff discussions according to the time they were taken so that observations could be easily cross referenced with what staff were discussing. The data extract below shows how observation notes were integrated into the transcripts.

F: And whatôs the function of that table?

(One man is drumming his fingers on the desk. Possibly disinterested or maybe he doesn't connect with what the facilitator is talking about) (Researcher's observation notes: Day one)

P2: Iôve no idea.

P7: Just writing down your observations and stuff.

P2: I donôt know itôs just a square thing (Day one: 1818-1885).

Staff members were numbered in relation to where they sat for the purposes of transcription so that when an individual spoke they could be identified. Pseudonyms were used for all other individuals mentioned during the away days. Names of places (such as wards) that could be identified were anonymised. The completed transcripts are attached as an addendum to the thesis.

2.10 Analysis

Consistent with the approach to thematic analysis posited by Braun and Clarke (2006), a number of decisions were considered and made prior to the analysis commencing:

- A thematic unit was considered to be any response by a participant to the formulation specifically or away days more generally.
- Rather than a thematic description of the entire data set a detailed account of particular aspects of the data set was aimed for, which related to participantsô responses and was relevant to the research question.
- Inductive as opposed to theoretical thematic analysis was aimed for in order that the themes identified were strongly linked to the data themselves. A process of

coding the data without trying to fit it into a pre-existing coding frame or analytic preconceptions was adopted.

- The researcher aimed to identify themes at a semantic as well as latent level. This meant that responses were identified within the explicit meanings of what staff said, but underlying meanings and other types of response (e.g. affective or behavioural responses to the formulation) were also considered by the researcher and in academic supervision.

The analytic process itself involved a progression through the six stages of analysis suggested by Braun and Clarke (2006). Table 2 outlines these phases.

Table 2. *Phases of thematic analysis*

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribe data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic map of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

2.11 Ensuring quality

The trainee read the data several times before coding began to write down initial thoughts and ideas about staffs responses in each transcript. Significant information such as participantsô use of language or expression of feeling was written in the left hand margin to begin with. Following this, the researcher collected relevant comments into codes and then

started documenting potential themes in the right hand margin. The trainee kept a rigorous method of detailing how theme names changed shape and where in the transcript evidence for each theme came from. Themes were reviewed and checked against coded extracts and contradictory comments. Negative cases were also looked for.

Standards of good practice as outlined by Stiles (1993) include the researcherôs orientation and preconceptions, repeated rotation between data and interpretation, close engagement with the data and the grounding of interpretations with examples (Stiles, 1993). The researcher ensured quality standards were met throughout the research process by immersing herself in the data and meeting with her academic supervisor regularly to reflect on the process. She was reflexive in her role as an observer and researcher and spent time thinking about how her epistemological position and personal experiences impacted on the research (see Appendix M).

3. Analysis of data

3.1 Introduction

Results draw from three types of data: transcribed discussions between staff and the facilitator from both away days; the researcherôs observation notes made during both away days and data from the staff evaluation forms.

3.2 Findings relating to staff responses during the away days

Findings in this section draw on the thematic analysis of discussions between staff and the facilitator from both away days as well as the researcherôs observation notes during. Six main themes and twenty three sub-themes are presented to provide an overall story of the findings (Braun & Clarke, 2006). A diagram is presented (figure 1.) that illustrates how the main themes relate to the formulation and to each other. The two theme boxes that óoverlapô with the formulation indicate responses that were in accordance with the formulation. The theme box with the two arrows indicates the way in which information in this theme had potential to develop the formulation. The other theme boxes represent ways in which staff engaged with the formulation at different points in the day.

Examples from the transcripts are taken either from the researcherôs observation notes which are indicated or from staff discussions in which case óPô refers to a member of staff (e.g. P2) and óFô refers to the facilitator (e.g. F). Information highlighting the day (e.g. day one) and line number in the transcript is also illustrated for example: Day two: 167-172. NR was a code used to symbolise small amounts of talk that were not deemed relevant to

the sub-theme and were therefore excluded from the report due limits of the word count. A bracketed full stop (e.g. (.)) refers to pauses and bracketed numbers (e.g. (5)) to number of seconds of silence.

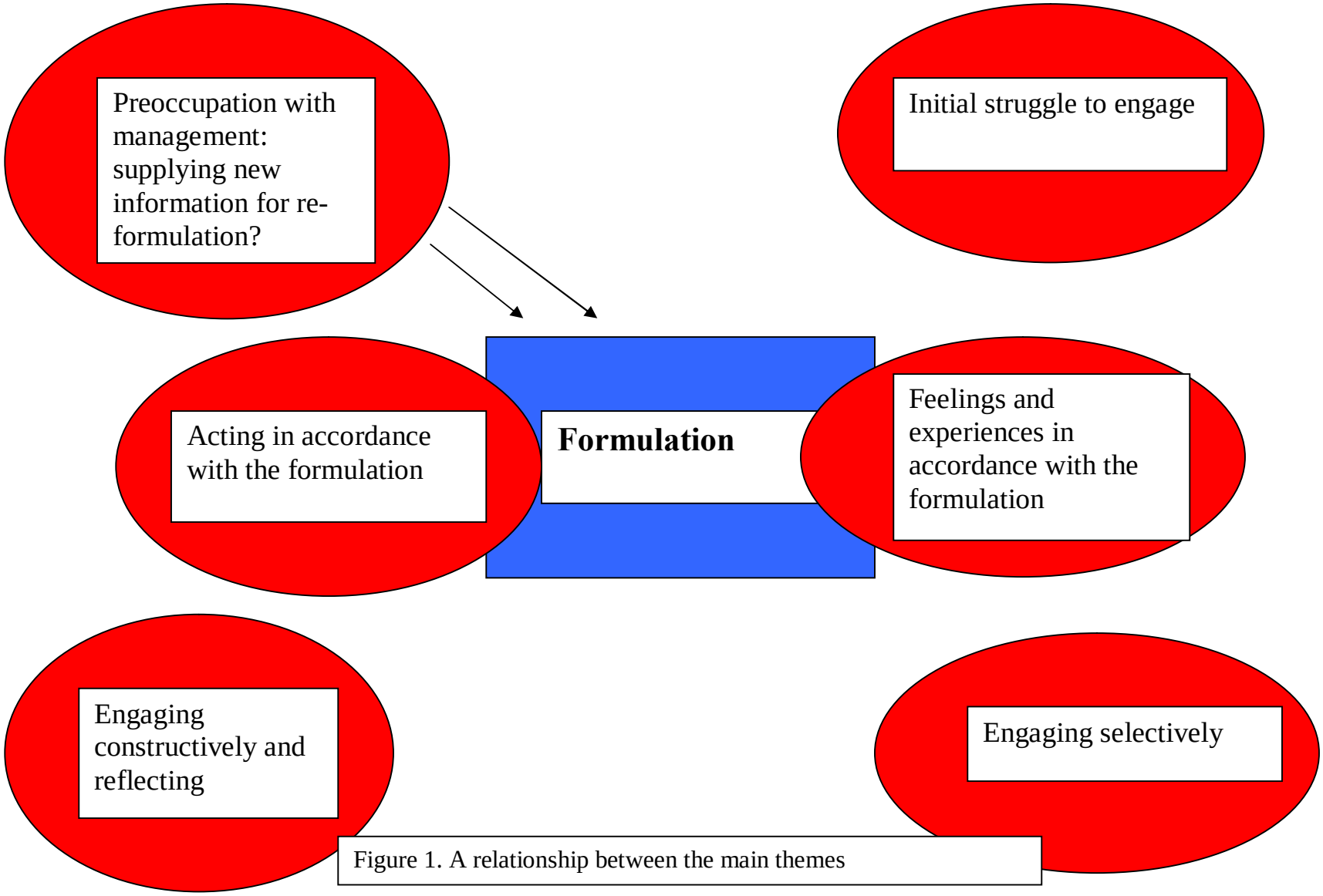

Figure 1. A relationship between the main themes

3.2.1 Main theme: Initially struggling to engage

This theme describes a process whereby staff appeared to struggle initially to engage with both days, appearing threatened and apprehensive. This related to the atmosphere in the room, remarks made by staff during arrival, and in the apparent indifference expressed about the day. Both groups used banter and laughter, in a way which made it appear like an attempt to make the start of the day feel safer.

3.2.1.1 Sub-theme one: Feeling threatened and apprehensive

This sub-theme captures the researcherôs observation that staff appeared threatened at the beginning of day one and that the atmosphere felt tense and prickly. This was supported by a comment made by one member of staff conveying a strong sense of anxiety about conversations being audio recorded. On day two staff seemed apprehensive although there also seemed to be some curiosity as a couple of individuals approached the researcher at the start of the day and asked her about the research. The slightly warmer atmosphere on day two may be explained in part by a comment made by one member of staff that she ôhad heard good reports about yesterdayô(p21).

The atmosphere felt tense and prickly. I was very aware of my presence in the room as an unfamiliar face. No one said hello to me or introduced themselves. I asked a couple of people if they found the building okay…someone asked if everyone had signed the consent

form and another replied 'someone shoved it in my hand and made me sign it and told me not to bother reading it'. Several people laughed. I overheard one member of staff saying 'as soon as the microphone goes on I am not saying a word' (Researcherôs observation notes; start of day one).

3.2.1.2 Sub-theme two: Dismissing the value of the day

This sub theme refers to the response by staff when the facilitator asked them what they would like to get out of the day. Long silences on both days appeared to be linked to an ambivalence to engage and then comments were made which were dismissive of what might be on offer and conveyed a lack of interest. A remark about it being part of ógeneral trainingô also suggested an attempt by staff to make the day feel familiar.

F: é what I want to do first is really um, is get a sense from you about what you would like to get from today because (.) this is your day, (.)é it might be useful for me to know a bit about what you are hoping to um you (NR) (5)

P2: I just want to have a laugh and go home early (lots of laughter) (Day two; 24-30).

3.2.2 Main theme: Describing feelings and experiences that are in accordance with the formulation

This theme captures the feelings and experiences shared by staff that appeared to match the formulation. This related firstly to the idea in the formulation that staff could lack

confidence in their practice and could feel at times like nothing they did was good enough. Staff appeared to confirm this during the away days by expressing feelings of impotence and self doubt particularly attached their work with patients. In the formulation it was also understood that staff could fear doing the ówrong thingô and what that could mean in a culture of blame, which again seemed to be confirmed by staff who expressed feelings of anxiety about being criticised and ómistakesô being held against them. Finally, in the formulation it was suggested that staffsô task of engaging with patients was anxiety provoking and that they had a tendency to relate to patients in a detached way in order to protect themselves emotionally. This was substantiated by a small number of staff who described a need to ócut offô from patients emotionally. These descriptions were seen to confirm in a straightforward way the accuracy of ideas in the formulation about staffsô experiences.

3.2.2.1 Sub theme one: Expressing feelings of impotence and anxiety

This sub-theme highlights the feeling of impotence expressed by staff across both days which related to an anxiety about failing to ófixô or ósaveô patients because of not being óproperô nurses or óbad nursesô. Feelings of self-doubt and a questioning of whether they were doing things the óright wayô were mirrored in the formulation where it was understood that the staffôs task of caring for patients was anxiety-provoking and that staff carried a fear of ógetting it wrongô and feeling like they were ónot good enoughô.

P9: I don't know if someone has said this already. Sometimes I question myself (.). I am doing things right? Maybe I cannot accomplish things because I am not doing things the right way

P4: It's that self doubt isn't it?

F: Yeah absolutely I think it's that constantly self doubting

P9: Yeah (Day two: 167-172).

3.2.2.2 Sub-theme two: Expressing significant anxiety about being criticised.

Staff on both days expressed significant anxiety about making decisions, particularly those relating to patient care and managing risk. Getting something wrong and being made to feel personally responsible were significant fears as was the fear of the potentially catastrophic consequences if something did go wrong. Several staff referred to the need to justify their decisions in order to protect themselves. However, paradoxically there was a sense from other staff that there was nothing they could do to protect themselves and that criticism and blame could come at anytime. These anxieties related to a part of the formulation where it was hypothesised that staff felt constantly that they had to 'cover themselves' and the danger of saying or doing the 'wrong' thing in a culture of blame.

P19: You look over your shoulder before you do anything and you think well not I am not going to make that decision because I could be criticised or it could have a detriment to my job (Day two: 150-152).

3.2.2.3 Sub-theme three: A small number of powerful descriptions of cutting off emotionally

This sub-theme represents reflective comments from staff about the need to cut-off emotionally in order to do the job. A small number of comments made up this sub-theme but these were important in acknowledging that being with patients could be difficult and could evoke feelings that are hard to manage. Comments showed strong accordance with the formulation, which suggested that the task of engaging with patients was anxiety provoking and that staff could detach from the difficult emotions evoked in their work by depersonalising patients and acting in a professional role.

P11: é So that is what I am trying to say about the emotional part is that it is very difficult in terms of if you are talking to a patient and they are telling you something that makes you want to cry, you have to try and suppress that so hard to continue engaging with themé (Day two: 1531-1533).

3.2.3 Main theme: Acting in ways consistent with the formulation

This theme refers not so much to what staff said, but the way they behaved that appeared to be in accordance with the formulation or seemed to demonstrate a difficulty with something talked about in the formulation. This referred to a difficulty thinking empathically about patients and a tendency to construct patients as two dimensional. A

ópromoô with being too busy on the ward was also talked about in the formulation and by staff during the away days.

3.2.3.1 Sub-theme one: Losing the capacity for empathy

It was apparent on both days that staff found it hard to think empathically about patients and spoke at times in a disparaging or pejorative way about patients. Staffôs understanding of patients behaviour appeared to be simplistic (e.g. patients were trying to seek attention) critical and lacking in empathy or understanding from a more holistic or psychological perspective. A feeling that patients could deliberately be manipulative and cause trouble was also expressed. Staff appeared to be demonstrating through these comments an idea outlined in the formulation about ólosing the capacity to empathiseô. The following two examples illustrate this.

P4: é I mean some of the patients you can almost look at your watch and know that they will be coming in, you know. Itôs the end of the month, Iôve got no money, I have got no food, you know, I will just come in for a meal and you know we are not a hotel (Day one: 1070-1073).

F: What you get is people switching off from any sort of compassion and

P18: Well you just think, no wonder you are the way that you are

F: Yes, your fault and thatôs how you end up feeling

P18: Yeah, exactly (Day two: 1673-1677).

3.2.3.2 Sub theme two: Drawing attention to the challenge of working with patients with a personality disorder diagnosis

Repeatedly during both days staff were observed changing the course of the conversation to talk about the difficulties they experienced working with someone with a personality disorder. Fixed ideas about what it meant to have this diagnosis were expressed for example, being manipulative, óhaving their own agendaô and ónothing being good enoughô. Differences between patients and the complexity of someoneôs presentation seemed to be over-looked. This fits with what was suggested in the formulation about a tendency by staff to construct patients in two-dimensional ways as a way of imposing some certainty on a situation (being with patients) that felt uncertain.

P2: I don't think it matters with personalities (personality disorders) does it. It doesn't matter how much you effing put in it's never enough and that's

P4: Yeah exactly, that's how I feel

P3: Its never straightforward is it with them (NR)

P4: I tend to find that they are just finding problems, you know you help them with one problem and they just come back with something else (Day one: 1552-1565).

3.2.3.3 Sub theme three: Describing being too busy to engage with patients; frustration and guilt attached to this

This sub theme represents discussions staff had on both days about being too busy on shift and the lack of time they had to spend with patients. Nurses explained that the organisational demands such as answering phones and paper work 'forced' them to stay in the office whereas Health Care Support Workers were left to be on the ward and deal with the 'emotional stuff'. Several staff expressed frustration and guilt about not having time to spend with patients and a few expressed some relief. This was thought to reflect what was described in the formulation as an 'action culture' and a rhetoric of 'being busy', understood to perhaps be a defence against the difficult task of engaging emotionally with patients. An absence of qualified staff on the ward was also noted in the formulation.

P18: But é (NR) people arenôt having that one to one time

P22: No exactly, they are not

P20: Because we are all too busy doing all the bliminôpaper chasing (Day two: 2522-2524).

3.2.4 Main theme: Preoccupation with management: supplying material for reformulation?

The current theme describes the way staff on both days were preoccupied with management, expressing a lack of faith in management and repeatedly raising and sharing difficulties they had with management relating to not feeling supported and not feeling listened to. Staff also expressed anger about being treated in what they felt was a cruel and punishing way. Issues staff had with management were found to dominate discussion for significant amounts of time on both days. It was thought that through theses discussions staff may be providing some new information about being on the ward that was important for developing the formulation or for re-formulation.

3.2.4.1 Sub theme one: Expressing a lack of faith in management

Staff on both days expressed a lack of faith in management and this appeared to be linked with the belief that managers lacked competency and the appropriate clinical background to be in the positions they were in. Criticism of individual managers as well as discussions

about the óbad decisionsô managers had taken for example, the smoking ban were apparent. There were many such comments relating to this in the transcripts.

P4: I think, I think management wise, my managers they need to have the same clinical background, they need to have worked in a clinical setting (Day one: 597-598).

3.2.4.2 Sub theme two: Sharing strong feelings of anger and upset about the way they feel they have been treated

This sub theme describes the way staff felt they were treated by management. Strong feelings of anger and upset were expressed relating to experiences of being unfairly blamed for things going wrong on the ward following a number of serious incidences and some individuals felt they had wrongly been made to feel personally responsible and then punished by their managers. The strength of feeling about this was evident in the use of powerful and evocative words, such as óabuseô to describe their experience. Dialogue relating to this was considerable in both transcripts.

P19: é you felt the pressure and the weight of the organisation with the, you know, with the punitive rod as it were coming around saying you havenôt done this and you havenôt done that and I, I felt that that was grossly unfair (147-150).

3.2.4.3 Sub theme three: Expressions of anger about a lack of support from management alongside expressions of support for each other

This represents the anger staff expressed about a lack of support from management and being overlooked despite efforts to make management aware of their needs. Feelings of abandonment were also apparent related to the seemingly unfair position of doing what they could to meet patientsô needs but then getting nothing back in return. Staff explained about the huge importance of receiving support from other colleagues in carrying on and described times when they had supported each other. In the absence of any support from ólaboveô, it appeared that staff were saying that they only had each other to rely upon.

F: So what keeps you coming in?

P20: The support of each other. The support of each other

F: Right

P20: Thatôs the crux of it. The support of each other

P22: You do need the support of each other (Day two: 414-418).

3.2.4.4 Sub theme five: Describe feeling disempowered and deskilled

This sub theme relates to the descriptions staff gave on both days about experiencing a lack of power within the organisational hierarchy. Feelings of frustration, helplessness and dejection were related to experiences of not being listened to and their views not holding any weight. Feeling deskilled appeared to be an extension of a lack of power as staff described not feeling able to exercise their own thoughts and skills at work and instead

having to ófollow ordersô from management and work in what was described as a mechanistic way.

P11: é So that is what is really hurting. It hurts! That is the hurt that is there. It is painful. Because when I came, I came to work as a nurse, but I think I have been transformed to work as a soldier (Day one: 481-483).

3.2.4.5 Sub theme five: Expressing strong feelings of anxiety and upset about the pressures put upon them

This sub theme relates to the considerable amount of time staff spent talking about the pressures and expectations they felt were put upon them by management. The word óimpossibleô was used by staff on both days and this appeared to relate to the increasing demands of paperwork and administration combined with being understaffed. Feelings of anxiety, exhaustion, stress and distress were related to this. A feeling that management did not understand their task and set unrealistic expectations came across strongly.

P18: Thereôs just more and more things for us to, to do and itôs
more and more pressure and
P22: yeah more tasks, more paperwork, more people to supervise
P20: Yeah more jobs to do (Day two: 360-363).

3.2.4.6 Sub theme six: Despondency with the culture of paper work and nostalgia for times when they felt more able to engage with patients

An atmosphere of despondency about current ways of working permeated the transcripts of both days. This appeared to be linked to a feeling amongst staff that management had created a working culture where paperwork was more important than patient contact. There was a sadness in staffs descriptions of not knowing their patients; sometimes not even knowing their names and not being able to help patients move on. A sense that their task had become meaningless was conveyed in staffôs comments about ógoing round in circlesô with patients. Staff on both days referred to times in the past they had felt more positive about practice and this related to having the opportunity to build relationships with patients.

P3: I think for me (sighs). When you are sort of ordering a voluntary driver for someone for the 25th time and its oh are they coming or going this time (NR), you just think (.) well we are not achieving anything anyway so and itôs all just going round in a circle (laugher). Then you get a phone call, so and so is being admitted and they only got discharged a couple of weeks ago and you just think oh here we go what are we doing anyway so (Day one: 1053-1059).

3.2.5 Main theme: Engaging selectively with ideas and with the process

This theme relates to what staff did and did not appear to engage with over the course of the two days. For example, staff appeared to engage with an idea central to the formulation that the task of caring is difficult. On the other hand staff appeared to disengage from discussion about the part of the formulation that considered patientsô states of mind and also responded dismissively to some of the ideas about ways of working that were suggested in the formulation as functional in protecting staff from getting too close to patients. An engagement with the idea of being a coherent team that does good work was noticeable whereas thinking about difficulties within the team and things they may not be doing so well was less apparent. A selective engagement with processes during the days seemed evident in comments staff made at the end of each day, suggesting perhaps they had gained something from the process of talking and being contained by the facilitator more than learning about and reflecting on ideas in the formulation. It was noticeable that a number of individuals on both days said nothing at all which may also have represented something of a struggle to engage.

3.2.5.1 Sub-theme one: Engaging with the idea that caring for patients is difficult

Staff appeared to struggle at first with the idea that the task of caring is difficult, responding with an apparent lack of understanding of what the facilitator had said or blaming management for making it hard. Later on, however, staff discussed the challenges of caring and how work in the office could feel very different from the emotional demands

of caring for patients which was described as ófrustratingô, ócomplicatedôófutileôand óemotionally painfulô. Several individuals shared examples of times they had felt too tired or hopeless to care. There was a significant engagement with the idea central to the formulation that caring for patients is difficult.

P3: I think for me in the office, (NR). Itôs actually easier work in a way because you are not interacting with difficult patients and you know you are just organising things and talking to doctors, you know. I donôt think I am a nurse anymore I think I am just ward co coordinator sort of thing (Day one: 924-930).

3.2.5.2 Sub-theme two: Cutting off from material concerning patients' states of mind

Repeatedly staff were observed cutting off from discussions concerning patients states of mind when invited to think about this by the facilitator. This involved changing the subject, laughing and joking about patientsôexperiences, talking about patientsô challenging behaviour and talking about the ótroubleôpatients could cause on the ward. It was apparent that staff struggled to engage with the part of the formulation that considered the emotional experiences or internal worlds of patients. Interestingly, this response mirrored the suggestion in the formulation that staff had a difficulty engaging with patients emotionally on the ward. The example below is a good illustration of the facilitator inviting staff to think about the emotional experience of patientsôand the staff member responding by talking about patientsôbehaviour.

F: é what I guess I am trying to think about is that irrespective of someoneôs diagnosis, what is that individual grappling with? Um, even if they have got a diagnosis of schizophrenia what are they grappling with internally? What is someone with a diagnosis of personality disorder grappling with? (NR) what is going on internally for this person um why are they behaving in this way?...

P7: I mean only one or two patients with personality disorder go on level one and the ward totally is changed. Ask anyone um, it is just so different (Day one: 1661-1664).

3.2.5.3 Sub-theme three: Difficulty at times engaging with ideas about defences

This captures the difficulty staff appeared to have engaging with some of the ideas in the formulation about organisational defences; that is systems and ways of working that may be functional in protecting staff from some of the anxieties related to their task. Comments were made by staff on day one which dismissed the idea of defences and suggested that the facilitator was making óa fuss about nothingô. On day two, staff were observed changing the subject and blaming management for the defences being in place. A struggle to think at times about defences and their function was apparent.

F: é another defence was um

another defence was, she was interested in the function

of the nursing table because she wanted to sit behind it umé

F: And whatôs the function of that table?

(One man is drumming his fingers on the desk. Possibly disinterested or maybe he doesn't connect with what the facilitator is talking about) (Researcher's observation notes: Day one)

P2: Iôve no idea (NR)

P7: Just writing down your observations and stuff

P2: I donôt know itôs just a square thing (Day one: 1818-1885).

3.2.5.4 Sub-theme four: Withholding thoughts

This sub-theme refers to the significant number of individuals (three on day one and four on day two) who said nothing at all. The withholding of thoughts from these members of staff was hypothesised to be a difficulty engaging which may have related to the material being discussed or to the dynamics in the room (e.g. presence of the ward manager) which may have made it difficult to for them to feel comfortable sharing their views.

3.2.4.5 Sub-theme four: Overemphasising the coherence and competence of the team and the problems of those outside of the team

This represents the comments staff made on both days praising each other and referring to the good work they did as a team. Tensions were spoken about tentatively on day two, but much more frequent were comments emphasising the coherence of the team. Comparatively, staff expressed a lack of trust in the competency of others outside of the permanent team including bank staff, students, medics and community teams who were criticised for ónot doing anythingô ógetting things wrongô or ónot having a clueô. It appeared that staff found it difficult to engage with thinking about difficulties that may exist within the team and aspects of work they may not be doing so well.

P22: Because we know that we do a good job

P18: Mmmm yeah

P22: With the resources we have got we do do a good job and with
the amount of people that walk through that door and then
walk out again (Day two 801-805).

3.2.5.6 Sub-theme five: Appreciating the chance to talk and be contained

Appreciating the chance to talk and be contained captures what staff appeared to be describing as the most helpful and valuable parts of the two days when responding to the facilitatorôs question about what they were going to take away from the days. The process

of sharing difficulties, being listened to and having their feelings validated was something that seemed to engage staff more than learning about and reflecting upon the formulation.

F: é I will approach this differently or maybe
what will you take away from today. What are you going to take away? (5)

P21: Itôs been (NR)

P22: yeah

P:21 Itôs been to have those feelings acknowledged and thatôs how
we feel at work itôs been, you know the anxiety and the stress to have that
acknowledged is nice (Day two: 3551-1554).

3.2.6 Main theme: Engaging constructively and reflecting

This theme captures the ways in which staff appeared to engage constructively with ideas in the formulation. It also relates to the process whereby staff became more reflective about their work, reflecting for example, on their contribution to difficulties. A sense of agency was apparent towards the end of each day when staff engaged with reflecting on different ways of working.

3.2.6.1 Sub theme one: Engaging with thinking about ideas in the formulation about defences

A small number of comments from staff showed them engaging with ideas in the formulation about the personal and organisational defences. Staff engaged by sharing their understanding of the defence and why it might be there and also offered examples from practice about when a defence might have been used. At these times, staff appeared to be engaging constructively with ideas in the formulation.

P22: Itôs kind of a line of defence though (the nurses table)

P21: Yeah it is, yeah

F: Yes whatôs it a defence for, whatôs it? I mean I really think thatôs a really

P22: I donôt know um, itôs just somewhere I mean youôve got something to if someone (.) because it is volatile at times (.) if someone does decide to come and attack you maybe or whether that be verbally or physically there is something in the way.

F: Yes

P22: (NR) whereas if you just stand in the middle of the ward you have got not barrier what so ever (Day two: 2779-2792).

3.2.6.2: Sub theme two: Reflect on their contribution to difficulties

This sub-theme captures the reflective comments staff made about how they might be contributing to difficulties on the ward; in particular the difficulty of being busy. Several comments related to staff finding it hard to say no to patients and requests from MDT colleagues and they also spoke about the expectations they set for themselves. It appeared that by engaging with the day staff were enabled to reflect on the part they played in difficulties that had been discussed.

P3: Yeah, because sometimes I think we are unrealistic in what we expect of ourselves.

F: Yeah

P3: Because we will have a ward round and then you think ôright I am going to try and get all of these jobs done before I leave at 3.30 and itôs completely unrealistic, and in a way there is no need to rush (Day one: 2487-2493).

3.2.6.3 Sub theme three: Reflect on other ways of working and propose changes that they can make as a team

This represents the discussions staff had about alternative ways of working and the sharing of experiences of working on other wards and in other settings. A sense of agency was apparent in comments towards the end of both days when several members of staff

discussed and offered ideas about changes they could make as team to ease the pressure on themselves, for example, spreading administrative tasks out over the week. It seemed that engaging with the day had somehow created a space for thinking and reflecting about how things could be done differently.

P20: Well I think like you say in regards to us moving to the new

ward, that is an opportunity to for things to change to move forward in a positive way

um, if it comes to fruition that there isnôt a nursing desk then use that to our advantage to kind of shape the environment maybe? And adjust the environment?

F: Yep

P20: With the view to hopefully improving (Day two: 3087-3102).

3.3. Findings from the staff evaluation forms

Findings from the staff evaluation forms can be found in appendix N. Results indicated that staff felt generally positive about both days and felt they were a good opportunity to reflect. Consistent with findings from the sub-theme óappreciating the chance to talk and be containedô, several staff reported that it was ógood to be listened toô in response to the question ówhat are your initial reactions to the day?ô. Importantly most staff reported that they felt able to share most of the things they wanted to during both days. This supports the idea that staff felt comfortable talking openly during the away days and that discussions analysed above were an accurate reflection of staff views.

4. Discussion

4.1 *Summary of the Research Project*

The current study aimed to explore staff responses to a formulation based upon a psychodynamic ward observation study (Tilbury, 2012; unpublished thesis). Six main themes were developed capturing the different types of response staff had to the days. After an initial struggle to engage, staff went on to engage with discussion about material from parts of the formulation that were hypothesised as more palatable to staff. They reacted dismissively to or cut off from conversation about other parts of the formulation which were hypothesised as more anxiety provoking, for example, the emotional and psychological experiences of patients on the ward. Staff expressed feelings and experiences and also acted in ways that appeared to be in accordance with the formulation. The experience of being listened to and understood by a facilitator, with whom they had an established therapeutic relationship, was valued by staff. By the end of both days staff began reflecting creatively on how things could be done differently on the ward.

4*.2.1 Main theme one: Initially struggling to engage*

It is possible that staffôs initial struggle to engage reflected a lack of interest or that they were not finding the away days meaningful. However, there was no indication of this in the results of the staff evaluation forms. An alternative understanding may be that staffôs initial struggle to engage represented an anxiety about getting in touch with feelings related to

their work. Hinshelwood (2000) highlighted the complexity of feeding back psychoanalytic observations to participants and the likelihood that this would provoke significant anxiety due to the nature of interpreting a staff groupôs defences and exposing them to previously unconscious anxieties. The formulation suggested that staff in the current study could be profoundly affected by their work and could experience strong, mixed and potentially disturbing feelings of for example, love, hate, pity and guilt towards patients. This has also has been suggested in previous psychodynamic observation studies (e.g. Menzies Lyth, 1960). Given the idea in the psychotherapy literature that engagement for an individual in therapy is expected to take time due to the nature of what is being discussed (Lemma, 2003), it perhaps make sense that staffôs engagement in the away days was not immediate, as there may have been some anxiety about encountering feelings suggested in the formulation.

Fear of criticism may also have played a part in staffôs initial ambivalence as they later reported experiencing increased levels of recent criticism following a number of serious incidences on the ward. A sense that staff were hyper vigilant to criticism came across as the days unfolded.

4.2.2 Main theme two: Feelings and experiences that were in accordance with the formulation

In the formulation it was understood that staff could feel at times like nothing they did was good enough and in order to avoid this feeling could relate to patients in an emotionally

detached way through short exchanges. This appeared to be confirmed by staff during the away days who expressed feelings of impotence and self doubt and described a need to cut off emotionally in order to manage their interactions with patients. Such accounts are consistent with previous findings. Donati (1989; cited in Hinshelwood, 2000) for example, explained how staff distanced themselves from patients in what was described as ótouch and go behavioursô, which maintained ódepersonalised relationshipsôon a chronic long stay psychiatric ward. Meegens and Van Meijel (2006) also found that staff withdrew emotionally from patients. These ways of relating maybe understood by Chiesa (1993) who suggested that when engaging with acutely disturbed patients staff can experience unconsciously, anxieties such as fragmentation, worthlessness and hopelessness.

Anxiety about ógetting it wrongôand working in a culture of blame was also articulated in the formulation as well as by staff during the away days, who expressed a strong fear of criticism and of ómistakesôbeing held against them. This has been found in other research within the NHS which has reported workers to characterise their organisational culture as unforgiving and blaming (Atree, 2007; Brennan, 2006).

4.2.3 Main theme three: *Acting in accordance with the formulation*

Being busy on the ward was understood in the formulation as an organisational pressure as well as a way for staff to avoid spending time with patients. On the away days, a problem with being too busy was confirmed by staff who described excessive administrative duties

as has been reported elsewhere (Austin, 2009; Totman, 2011). The extent to which these prevented staff from being with patients was unclear, although many staff expressed frustration about not feeling like a proper nurse and some expressed guilt and sadness about abandoning patients. Some staff also admitted to preferring the 'easier' work in the office to the 'emotional stuff' on the ward, The 'problem' of being too busy therefore appeared complex, possibly more so than was suggested in the formulation and resulted in staff wrestling with confusing feelings, some of which (e.g. relief about not having to be with patients) may have conflicted with their idea of being a 'good carer'.

Other ways in which staff appeared to act as predicted by formulation during the away days was with a tendency to loose empathy for patients and a tendency to talk about patients in fixed, stereotypical ways, despite being encouraged by the facilitator to think about the complexity of patients. While it is possible that these responses represented a lack of interest from staff in this part of the formulation (the complexity of patients internal worlds), ideas from the psychotherapy literature suggest it maybe more complex. Lemma (2003) for example, argues that parts of a psychodynamic formulation will be easier for clients to hear than others and that while some parts maybe accessible to clients consciously other parts will relate to deep unconscious anxieties and conflicts which maybe inaccessible to them consciously. This understanding suggests that rather than a lack of interest, the difficulty with empathy displayed by staff during the away days may have reflected an unconscious anxiety about the part of the formulation that considered the mental pain and distress of patients and the pain that might be evoked in them through

really trying to empathise with the experience of such patients. Staff may not have been aware of these anxieties consciously.

Klein (1959) pointed out the significance of ópro jectionô in mental life and defined it as a capacity to attribute to other people around us feelings of various kind, predominantly love and hate. In the formulation staffôs difficulty with empathy was understood in terms of a process of projection; that is patientsôprojecting unwanted and unacknowledged feelings onto staff who then act as temporary vessels for these feelings to be located. This has been widely written about within the psychoanalytic literature (Menzies Lyth, 1960; Fagin, 2001).While not disregarding this idea, findings in the current study suggest that a more multi directional or systemic way of thinking about these difficulties may also be helpful. Parallel process has been defined in the psychoanalytic literature as an aspect of behavior or communication (sometimes unconscious) that happen at the same time (Watkins, 2012). This seems relevant to the current study which identified in other themes an experience for staff of lacking empathy or understanding from management which has been reported in previous studies (Brennan, 2006; Totman, 2011) and appeared to parallel their limited capacity for empathy for patients. It may have been therefore, that in addition to receiving projections from patients, staff were also caught up in ways of relating inherent within the organisation, involving a neglect of emotional experiences more generally.

4.2.4 Main theme four: Preoccupation with management: supplying material for reformulation?

The preoccupation staff had with management and their relationship with the wider organisation was an interesting response to the away days and one that was not evident in the formulation. Staff expressed anger for example, about the way they were treated and felt disempowered within the hierarchy and unable to use their professional judgement, as has been reported elsewhere (Totman, 2011). They characterised management as unresponsive to their needs and consistent with other findings expressed anger about a lack of support (Brennan et al., 2006; Parkin, 2011; unpublished thesis). It is possible that these issues were not part of the formulation because during the psychodynamic observation study, the method was perhaps not being used effectively by the observer which meant important influences on the ward were missed.

Another possibility is that the current study highlighted a limitation with the method more generally in terms of what might not be captured about a ward by studying it psycho-dynamically through observation. Staff expressed strong feelings of despondency for example, about working in a culture where they felt paper work was valued more than patient contact. The references staff made to times in past when they felt more able to engage with patients, suggested that the organisational culture was significant in how they worked and that it was less supporting of patient engagement than it once had been.

Fonagy (2001) has argued that psychodynamic theories poorly integrate the impact of the external world in their formulations. This is relevant to the current theme which, developed out of an observation that issues relating arguably to the world outside of the ward (e.g. management and the culture of the organisation) were ubiquitous in data from the away days but were not apparent in the formulation.

The British Psychological Societies guidance on formulation advices that one of the essential features of a formulation is that it is open to revision and re-formulation (Johnstone & Dallos, 2006). The current theme was useful in developing the formulation in the current study as it highlighted new avenues of understanding that appeared to have been opened up through the process of feedback. For example, the cultural factors mentioned above as well as a fear of personal retribution from the ôblamingô organisation appeared to inhibit staff in the current study from spending time with patients. The unmet needs described by staff also suggested limitations to their capacity to care which seemed relevant to the formulation particularly the difficulty described with patient engagement.

4.2.5 Main theme five: Engaging selectively with ideas and processes

Staff appeared to struggle during the two days to think about patientsô emotional experiences and the function of ward policies that allowed them to keep a distance from patients. It is possible that this response represented a lack of interest from staff or that ideas offered in the formulation did not resonate with their experience. Masson (1988) views psychotherapy as inherently prone to distort another person's reality because the

therapist is blinkered by their own view of reality. It may have been that ideas offered by the formulation reflected the observerôs view of reality during the observation study and misrepresented the views of staff.

Another hypothesis is that this part of the formulation addressed an unconscious aspect of staff experience that was difficult for them to hear and think about. Lemma (2003) argues that psychotherapists will all encounter resistance in their patients to experiencing and thinking about certain feelings, thoughts or states or mind attached to an underlying anxiety. Psychoanalytic literature suggests that connecting with people with complex mental health difficulties is extremely painful and can involve coming into close contact with the experiences of severe mental pain, anxiety, breakdown and self-destructiveness (Hinshelwood & Skogstad, 2000; Lucus, 1993). These ideas would imply that the disengagement observed in the current study could be understood as an emotional pattern of response involving resistance that is seen in clients in psychotherapy when encountering difficult feelings. According to the literature, staff in current study may have been resisting connecting with possibly the most anxiety provoking aspect of their work; patientsô states of mind.

The initially dismissive response by staff to the idea that caring for patients can be difficult could also be understood as a resistance to getting in touch feelings they had about caring (e.g. that it is demanding, frustrating, painful) which may have conflicted with their idea of a ógood nurseô. Thurston (2003) argued that the expectation for nurses to be unceasingly

ógivingô is often internalised by nurses themselves, who then experience any deviation from this as a blow to self-esteem.

A criticism of the observational method is that visiting a ward for an hour over six weeks is not representative of what actually happens. This might explain why a number of staff said nothing at all during the away days as it may have been for these individuals that ideas in the formulation did not make sense or did not fit with their experience. However, no disagreement with the formulation was expressed in the staff evaluation forms and staff also reported that they felt able to share what they wanted to during the days. An alternative understanding maybe, that staff had some underlying anxiety about discussing ideas. A fear of open communication within staff teams in inpatient settings has been reported previously (Kurtz & Turner, 2007).

That staff went on to engage with discussion and share their feelings about material in the formulation (e.g. the challenges of caring), supports the idea that they found this part of formulation meaningful. This engagement may be understood within the context of the established supervisory and therapeutic relationship staff had with the facilitator which perhaps enabled them to feel safe. As Karpenko and Gidycz (2012) reported, supervisees demonstrate greater self-disclosure and expression of ideas when they feel safe and comfortable in supervision.

It is well documented that the therapeutic relationship is important for outcome regardless of theoretical approach and is therapeutic in itself (Carey et al., 2012). This might explain

why staff in the current study reported verbally and in the evaluation forms that the most helpful thing about the away days was being listened to and understood by the facilitator rather than learning about the theory of how their difficulties were understood within the formulation. Symington (2006) defined containment as the ability to embrace and accept all aspects of an emotion and also said that to be a container you need to be as familiar as possible with the feelings and thoughts of those you are working. Staff in the current study seemed to be describing what they gained from an experience of containment, enabled by the relationship they had with the facilitator.

Johnstone and Dallos (2006) make the point that a formulation not only helps the patient, but also helps the therapist to feel contained. It may be that the formulation in the current study provided some containment to the facilitator, enhancing her understanding of staffôs experience which may have then enabled her to contain staffôs feelings so effectively during the away days.

4.2.6 Main theme six: Engaging constructively and reflecting

At times during the away days staff spoke reflectively and engaged with discussion about material in the formulation for example, why the ward was organised and run as it was. They also reflected on their contribution to difficulties, for example the problem with being too busy. Towards the end of both days there was a sense of agency in the discussions staff had about changes they could make as team. Bion (1965) said that containment combined with well timed interpretations in psychotherapy can help to bring

about a constructive internal change of attitude and behaviour. It seems significant that in planning the away days the facilitator drew on Winnicottôs (2005) idea about interpretation and allowing the patient to arrive at an understanding themselves before offering an interpretation. This way of timing the days may have afforded staff a reflective space to explore ideas about the ward themselves before learning about the formulation. The containment offered by the facilitator may also have enabled a process where by staff were able to work towards a more reflective position in the afternoon and think about how things could be done differently. The processes identified in this theme support the idea in the literature that a formulation is not just a product you offer someone, but rather a process that develops between people in a relationship (Johnstone & Dallos, 2006).

4.3 Concluding comments

Staff responses are best understood by considering the pattern of themes as a whole as well as the processes involved. While some ideas and feelings shared by staff, appeared to confirm parts of the formulation, other ideas appeared to offer new material important for developing the formulation. It was significant that staff learnt about the formulation within the context of an established therapeutic relationship. It is possible that this familiarity may have inhibited staff from expressing disagreement with the formulation for fear of the impact of this on the alliance. However, the relationship also seemed to enable staff to talk openly in a way they may possibly not have done had the facilitator been a stranger or if they had been part of a traditional interview. As Hollway and Jefferson (2000) explain,

participants tend to present as ódefended subjectsô in an interview setting which is driven by the need to protect themselves from anxieties.

The current study looked in depth at the way staff responded as a group however, it is also possible that there were differences in responses between individuals that were not picked up on in the current analysis. Although feedback forms confirmed that staff felt able to share their views, it is possible, that dynamics on the days for example, the presence of the ward manager on day one and the deputy ward manager on day two had an affect on what was and was not discussed by staff. It is therefore important when interpreting the current results, to bear in mind the impact of the ógroup feedback designô on how staff reacted and the potential for results to have been different had responses been elicited through individual interviews, where individual differences in response may have been more apparent.

A further issue worth considering is the dynamic nature of staffs engagement and disengagement with different ideas during the away days which could be interpreted as disagreement or disapproval with certain parts of the formulation. However, disagreement was not evident in the staff evaluation forms and ideas from the psychotherapy literature relating to the nature of engagement, the complexities of a psychodynamic formulation and expected responses from clients in individual therapy including resistance, provide an alternative understanding of the nature of staffs engagement. In this case, findings in the current study help further explain the inherent anxieties of specific aspects of work on a psychiatric ward, particularly engagement with the emotional experience of patients.

4.4 What the current study means for the psychodynamic method of observation

The aim of the current study was the initial evaluation of the psychoanalytic method of observation. One of the criticisms of this method is that the observerôs subjective experience cannot be relied upon although findings in the current study went some way in challenging this demonstrating that feelings experienced by the observer on the ward (e.g. anxiety about not being good enough) matched those discussed by staff during the away days. Likewise the way the observer understood and formulated her observations and counter-transference with staff appeared to correspond with the way staff presented on the days (e.g. losing the capacity to empathise and thinking about patients in stereotypical ways). A further criticism of the method is that it is un ï falsifiable (Popper, 1959). This relates to the perception that if observations are not accepted as accurate it is assumed that the reader is being defensive. In the current study staff supplied information about the ward that was not in the formulation (e.g. dynamics of the organisation and staffs relationship with management) but appeared to have a significant bearing on how they worked. The results of the current study therefore provide some preliminary evidence of the validity of the psychoanalytic method of observation and also inform about possible limitations for example, aspects of a ward that might be more difficult to capture using this method.

4.5 Clinical implications

The current study confirmed the emotional demands and unmet needs of staff working on acute wards. Better support for staff within the organisation is required such as supervision and reflective practice that can provide containment and a space to verbalise dissatisfaction (Brennan et al., 2006; Flood et al., 2006).

Utilising psychodynamic concepts within supervision and reflective practice to help staff understand their experience and express and learn from counter transference feelings would be recommended (Thurston, 2003). Increased input from psychologists on inpatient wards may help facilitate this. An acknowledgement by supervisors and managers of the need for healthy and adaptive defences in the face of disturbing patient communication may also reduce the need for unhelpful defensive ways of coping to develop. The current study showed that bringing unconscious defensive practices to light could be a helpful endeavour within NHS settings. The dynamic nature of staffôs engagement with different parts of the formulation suggested the need for this to be done in a supportive and safe learning environment. The current study also suggest that using this method alongside other methods which pick up on more systematic issues would be worthwhile.

Highlighted in the current study were organisational and cultural factors that appeared to be obstructing professional-patient engagement. Despite the introduction of government initiatives that are highly focused on staffï patient interaction, (e.g. protected engagement time) it seems at present that the organisation is not facilitating of these. Instead, staff

report being constricted by excessive administrative demands and insufficient staffing levels **(**Brennan et al., 2006; Harrison, 1998). Changes in management practices allowing staff greater autonomy in work maybe a first step however, there is a need for more research focussing on the role of the organisation within inpatient environments especially given that commissioning powers are being passed to doctors (Franks, 2004). It will be interesting to see how this further affects the implementation of guidelines around patient engagement.

There is considerable scope for enhancing worker voice and relationships with senior management so that staff have a sense of real participation and involvement in decisions about the ward. Greater presence of senior managers on wards and opportunities for staff to be present at higher level Trust meetings might support this (Totman, 2011).

4.6 Limitations of study

One of the limitations of the current study was that due to difficulties releasing staff, the away days took place 18 months after the psychoanalytic observations were undertaken. In the meantime, rapid changes to the organisation took place in response to financial pressure to cut costs. Furthermore an unusually high number of serious incidences occurred on the ward, which as staff reported resulted in an atmosphere of investigation and blame as well as the introduction of new measures to manage risk. This may have meant that the ward was a slightly different place than had originally been observed.

That the researcher who undertook the psychoanalytic observations was unable to attend the away days is a further limitation as the facilitatorôs planning and delivery of the formulation will have inevitably involved her own selective interpretation of results. Although evaluation forms indicated that staff felt able to share their views during the days, it is possible that the attendance of the ward manager on day one and deputy ward manager on day two may have inhibited some staff from talking honestly. Enabling staff to attend as a whole team on one day may also have produced different results.

4.7 Future research

The innovative design of the present study extended recent studies which explored ward culture using the psychoanalytic method of observation (Blacker, 2009; unpublished thesis; Jones & Wright, 2008; Goodwin & Gore, 2000; Katz & Kirkland, 1990). The analysis of the staff responses to the results of a psychoanalytic observation study, contributed to the research process by offering some triangulation and a way of evaluating the model. Future research should focus on returning to the ward to investigate the clinical implication and any changes to the understanding and attitude of staff following the feedback process. Research is also required to further evaluate the model and investigate whether it can be of help in terms of bringing unconscious defensive practice to light within NHS settings.

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Section D

Critical Appraisal

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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. Selection of Research Topic

I first heard about the project when my academic supervisor came to present it as a potential thesis while I was in my first year of the Clinical Doctorate course. My interest was sparked initially because of the use of the psychodynamic model. Prior to starting the course, I worked for an Improving Access to Psychological Therapies (IAPT) service and my experience was one of working in a prescriptive way, where I felt frequently frustrated by clinical work as I was unable to explore clientsô difficulties in any depth. I found the psychodynamic model fascinating, ambitious and rich and was interested in the complexity of ideas, although I had a lot of questions about how it worked and whether it was effective. The idea of using this model in qualitative research excited me and I hoped to understand more about psychodynamic ideas and practice.

When initially thinking about my thesis, I was drawn to qualitative research rather than quantitative research, because I felt it suited my world view. Criticisms about the generalisability of qualitative studies and the fact that they are not representative are well known (Willig, 2008). However I was of the personal opinion that qualitative research fits more closely with the practice of clinical psychology by focusing on peoplesô personal experience. I also felt it had the potential to offer something more meaningful to the evidence base than quantitative methods which are limited in terms of what they can capture about psychological phenomena, particularly when using clinician devised

measures. Qualitative research can also be robust methodologically by documenting the process, allowing transparency (Attride-Stirling, 2001).

An additional reason for choosing this research was an interest I had in the experience of staff in acute mental inpatient settings. This stemmed from my previous work as a part time agency Health Care Assistant (HCA), before the course, which I found personally and emotionally challenging. I remember feeling like I could not work in this role full time and felt guilty about this and that somehow I wasnôt a good enough carer. My experience left me curious as to the impact of care work on staff and whether it was just me who felt these things. Although I had worked in various rehabilitation and inpatient settings I had not spend anytime working in a psychiatric inpatient setting, thus, I had fantasies about what it might be like to work there but no experiential knowledge to draw upon. Mainly my beliefs were negative about the patients being frightening and the work leaving you emotionally drained. I also imagined staff teams to be controlling towards patients and cynical about patient progress as well as relying heavily on the medical model. I felt that the subject of staff experience of working on an inpatient ward was one I could connect with and add something to from my own experiences of working within a care setting on the ófront lineô.

2. Learning more about the Psychodynamic model of observation

Before I decided on my research topic, I expressed an interest to the course tutors in learning more about the psychodynamic model and fortunately I was able to gain a

placement within a psychodynamic setting for a period of two years. During this time I worked with two individual clients, attended weekly supervisions with a Principal Psychotherapist and also took part in weekly seminar groups where psychodynamic theory was discussed with clinical material.

These experiences enhanced my interest and led me to first contact my supervisor to learn more about the current project. She advised me to familiarise myself with the method of observation and how it has been used in organisational settings and recommended that I read Hinshelwood and Skogstad (2000) ‘Observing Organisations. Anxiety, defence and culture in health care’. I also read papers by Menzies Lyth (1960), Goodwin and Gore (2000), and Jones and Wright (2008), which provided more clinical examples of the psychodynamic observation method being utilised for research purposes.

I found the method fascinating but also complicated and in-depth and found that I frequently had to go back and re-read parts of papers to understand the concepts. While working for IAPT I was required to complete numerous and frequent outcome measures with clients and had become disheartened and doubtful about measures relying on numbers and statements that seemed to miss out the dynamic quality of change within psychotherapy. What captured my attention in the psychodynamic model was the use of the concepts of transference and counter -transference, in understanding more about clients’. What struck me about psychodynamic ward observation studies, was the use of transference and the richness of responses to a ward environment and what they could add to an understanding of how such settings work. I was mindful of a criticism often leveled

at this method that it relies heavily on the subjective experience of the observer. The question of how reliable and valid psychodynamic observations are interested me and the idea of attempting to evaluate this method I thought was worthwhile.

3. Choice of Methodology

The idea of a thematic analysis of staff reactions to a formulation based on a psychodynamic ward observation study was approved by the University Peer Review panel as well as the local Trust Research and Development (R&D) department.

The away days were planned to go ahead in June 2012, however, due to concerns from management about the release of staff, significant delays ensued in finalising dates for the days. An extremely anxiety provoking period of uncertainty followed for me between June 2012 and December 2012, when I was waiting to hear about a date and did not know if the days would take place in time for me to include them in my research. The fact that I had no control over planning the days added to my anxiety and difficultly tolerating the unknown and I began to think about alternative ways in which I could take the research forward.

Through discussion with my supervisor, I decided to invite the Clinical Psychologist participant collaborator to take part in an interview in order to pilot my thematic analytic approach and also to provide an alternative data set in the event that the away days did not go ahead. I conducted two semi-structured interviews in November 2012 which explored the Clinical Psychologistôs individual response to findings from the psychodynamic

observation study and both interviews were transcribed and analysed. I also interviewed the Trainee Psychologist who undertook the psychodynamic observations to explore her retrospective reflections on the observations. This was particularly interesting given that she had spent time since undertaking her observations with the ward staff, facilitating reflective practice and had therefore gained a different perspective on the ward.

The away days were finally confirmed for February 2013 by which time I was able to step back and reflect upon the process that led to this point and what I had learnt about feelings that had been evoked by my research at various levels within the organisation. The Clinical Psychologist described the process of negotiating with management as ótortuousô and fed back to me that management viewed the away days as unnecessary as staff needed to just óget on with their jobsô. We wondered together about what this reaction might be about and talked about the possibility that there might be something threatening and uncomfortable for management about the research and staff knowing too much or becoming too aware and thoughtful. I reflected later on this first response to the formulation and how it influenced my expectations about the responses of ward staff during the away days.

I became aware that one of my counter transference responses to this process was to feel apologetic about the project that in some way I was óimposingô something on staff for the purposes of my doctoral research. I wondered if this was influenced by the negative response from management. It was only later, when I learnt more about the unmet needs of

the staff group, that I came to really believe the project to be worthwhile for staff and appreciate the clinical utility of what was on offer.

4. Attending the away days and observing

I found attending the away days a very interesting experience. I felt self conscious at first, like a ófly on the wallô in a staff meeting and this lead me to feel I was being intrusive by taking notes. However as each day unfolded I felt more comfortable.

I had been worried that being a passive observer, I would find it hard to stay engaged. However, I found I was interested in what staff were saying and could relate some of their feelings and experiences to my own clinical work, as well as my previous work as a HCA. I expected staff to be more defensive than they were towards ideas in the formulation and was surprised about the openness with which they discussed things. I was also shocked by some of things they were saying about the impact of their seemingly relentless and competing pressures. One nurseôs account of writing a care plan about someone she had not had time to even meet, stuck in my mind. Experiences they shared about ways in which they had been treated by management also struck me as extreme, cruel and nothing I had encountered before. On reflection, a week or so after the away days, I was able to see the complexity of the difficulties they were describing and began wondering about the impact of this on patients. However during the away day I feel I lost this perspective and identified very much with staffôs position.

5. Analysing the data

Initially I felt confident about conducting a thematic analysis having used this method in my undergraduate dissertation. However I found analysing the transcripts in the current project a confusing and complex process.

Given the large size of the data set and time constraints of the doctorate, I was unsure at first whether I would have time to analyse both days and so begun by immersing myself in day two; the day I felt had more to offer in terms of variety of staff responses. I started an initial stage of coding however I discovered a flaw in my analysis through discussion with my supervisor. This related to a process of coding in terms of the content of what staff were saying about their experience rather than coding for staff responses and this led me to re-code from the beginning which felt frustrating.

I understood this as an over engagement with staff experience which stemmed possibly from my position as an NHS employee and an interest in what they were saying about organisational dynamics and cultural changes which were affecting me in a similar way. I also thought about this over engagement as a counter-transference response reflecting the strength of feeling expressed by staff on the away days. Powerful words such as óabuseô and óinhumaneô for example, were used by staff to describe the way they had been treated by the organisation and this impacted on me powerfully. I was very aware that I was writing about real people, and on reflection I wondered if unconsciously, I felt a responsibility to put their óexperienceô óout thereô.

Slipping away from my research question and becoming over-engaged with what staff were saying was a difficulty I encountered at various points throughout the analysis and writing up process. While I tried to ensure that my analysis and interpretations were grounded in what participants said (Braun & Clark, 2006), the fact that I used the content of what staff were saying as exemplars for a type of response made the process confusing. My supervisor helped me to stay focused and I personally addressed this by ósteppingbackô from the data and thinking carefully about what I meant by a type of response (e.g. that a response could be intellectual, cognitive, affective or behavioural). I also kept a reflective journal which helped me track my own thoughts and reflections throughout the process. The suggestion by my supervisor to verbally explain in a general way my impressions about how staff responded during both days was very useful.

I recorded all supervision meetings I had, which helped me track the meaning- making of how initial codes became themes and how content illustrated response. I also kept a rigorous method of detailing how my theme names changed shape and where in the transcript evidence for each theme could be found. This was important in keeping my analytic process clear and transparent. It was also important considering my aforementioned work in care and the personal interest I had in the impact of care work on staff and how previous experiences can unknowingly influence researchers of any orientation (Morrow, 2005).

Whilst it felt like the analysis was quite an arduous process at times which involved a tussle to stay focussed, I believe I analysed the material thoroughly and thoughtfully. Once I had finished coding day two in a more effortful way, I found it easier to analyse day one and was able to continue to develop my initial ideas about response as I went along.

Throughout the analysis I was aware of my interest and belief in the value of the psychodynamic model and observation method and the possible bias this introduced in terms of me expecting to find confirmation of the accuracy of the formulation in staff responses. Braun and Clarke (2006) talk about the importance of the researcher being aware of the fit between data and claims made and to consider negative cases. Taking this on board, I made an effort to try to find negative cases in the transcript and I found this helped my analysis as themes emerged which I was surprised by (for example, staffsô preoccupation with management, an issue absent from the formulation). In the end, developing categories that did not fit or were different from the formulation was the part of the process I found most exciting.

One reflection, I wondered if a further influence on my approach to the analysis was the friendship I had with the Trainee Psychologist who had carried out the psychodynamic observations which had developed through us spending time together on placement. It is possible that at some level I worried about evaluating her work and the potential for this to be received critically. I also wondered if my relationship with her motivated me unconsciously to produce a piece of work that validated her research.

6. The impact of the interviews

Interviewing the Clinical Psychologist participant collaborator was a valuable process in terms of piloting my thematic analytic approach and also in terms of learning more about the staff group and the experience of being on the ward. On the other hand, I reflected that this experience led me to develop certain preconceived ideas about what I might expect in terms of the responses of ward staff. The Clinical Psychologist for example, had a very positive response to the observations. She said they órang trueô and that she could órecognise and identify with what was observedô in terms of her own experience on the ward. I believe this enhanced my belief in the method and possibly led me to expect ward staff responses to be equally as confirming of the observations.

Discussion with my supervisor helped me understand the complexity of staffôs response and I found drawing on the literature about engagement and process in psychotherapy also very useful (Lemma, 2003) in deciphering the different types of responses staff had to different parts of formulation. Some responses for example, seemed to reflect a straightforward agreement with parts of the formulation, that were perhaps more palatable to staff (for example, discussing the challenges of their job). Other types of response appeared to reflect resistance to or disengagement from parts of the formulation that were maybe harder to hear or even inaccessible to them consciously (for example, patientsô states of mind). I remained mindful that this was only a hypothesis and that it was also possible that parts of the formulation did not resonate for staff at all.

Thinking about the process of sharing formulations with clients in my own clinical work helped me to make further sense of the different multi-faceted ways in which staff were responding.

Whilst my experiences of conducting the interviews shaped me and made me sensitive to certain parts of the transcript more than others, I do not believe that this made the data redundant. Rather the analysis of interviews gave me a baseline against which to measure my analytic process.

7. Limitations of the social action approach

The methodological approach for the current study was informed by the Action Research approach which involves the detailed study of clinical practice (Dallos & Smith; unpublished paper). The away days had been planned by the ward in conjunction with the researcher who undertook the psychodynamic observations and would have gone ahead whether the current research was planned or not. In this sense data arising from the away days was naturalistic and the current study was thought about as a detailed evaluation and write-up of a naturally occurring piece of clinical work between a psychologist and nursing group.

While considering this approach a strength, I was also aware that the current research was not a conventional qualitative study and at times this caused me some concern. For example, I worried about staff discussions veering away from discussion of the

formulation during the away days, and I wondered how the results might have been different had I had more control over the process, using perhaps an interview approach and designing my own agenda of questions. However, the data represented naturally occurring discussions between staff and it is likely that certain themes in the current study would not have been elicited through a traditional interview approach. Holloway and Jefferson (2000) for example, spoke about the concept of the ódefended subjectô and how participants tend to present in defended ways in an interview setting to protect vulnerable parts of themselves which can limit the data.

One aspect of analysis in the current study which could be questioned, is in relation to the assumption that the staff group (over both days) were a homogenous group as it is possible that there may have been differences in responses between individuals. Difference may have stemmed for example, from the different professional roles staff had within the team and the differing lengths of time they had been working on the ward and in the Trust. It was a limitation of the current study that individual responses could not be explored. However, the psychodynamic observation method is based on the idea of óorganisational defencesô; that is ways in which a staff groups and organisations work in order to protect the workforce as whole from anxieties inherent in their task (Hinshelwood & Skogstad, 2000). In this sense, I believe that it was helpful to consider staffôs response as a whole in the current study.

I also wondered about the facilitatorôs role in influencing results that emerged from the current study. This related firstly to the use of technical language during the away days or

words that could be perceived as colloquial to the psychodynamic model for example, ócounter-transferenceô, ódefenceôand ócontainmentô. I wondered if there was a shared understanding amongst staff about what these concepts meant, and if not, how this influenced the process of staff making meaning of the formulation. In addition to this, I wondered about the facilitatorôs sensitive approach to the delivery of material in the formulation and her desire to óprotectôstaff and what this meant in terms of her accuracy in reflecting the original findings of psychodynamic observations study. One of the themes that emerged from interviewing the facilitator (Clinical Psychologist participant collaborator), for example, related to ónxiety about how the ideas might be received by the staff groupô. I wondered if her concern about ótransformingôthe observations into something that would be palatable to staff meant that what staff heard about during the away days differed from the original findings.

9. Professional development

This study was intended as an initial exploratory evaluation of the psychodynamic method of observation.

I have found it exciting and fascinating to be part of such an innovative study. I feel I have learnt a great deal about the psychodynamic approach to observations, the value of this for understanding a culture of a ward and well as being able to explore initial ideas about possible limitations of the method.

I feel that the opportunity this research offered and what I have learnt about how anxieties and pressures are managed organisationally will be invaluable to me in the future as the role of a Clinical Psychologist is expanding and is more commonly involving consultative work with different staff teams.

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Section E

Appendices

Submitted May 2013

By

Katherine Foley

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
Advertising Information
Editorial by Steve W. J. Kozlowski, Editor (PDF, 28KB), January 2009
Please consult APA's Instructions for All Authors for information regarding
Manuscript Preparation
 Submitting Supplemental Materials
 Abstract and Keywords
 References
 Figures
 Permissions
 Publication Policies
 Ethical Principles

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 Steve W. J. Kozlowski, PhD Department of Psychology 309 Psychology Building Michigan State University East Lansing, MI 48824-1116
General correspondence may be directed to the Editor's Office.
In addition to addresses and phone numbers, please supply email addresses and fax numbers, if available, for potential use by the editorial office and later by the production office.
Keep a copy of the manuscript to guard against loss.
Manuscripts submitted for publication consideration in the ***Journal of Applied Psychology*** are evaluated according to the following criteria:
 degree to which the manuscript fits the mission of the journal;
 significance of the theoretical and/or methodological contributions;
 quality of the literature review;
 articulation and explication of the conceptual rationale, constructs, and psychological processes;
 rigor of the design and execution of the study;
 appropriateness of the analysis and interpretation of the results;
 discussion of implications for theory, research, and application; and
 clarity of presentation.

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. 13ï 15.

Appendix B: Literature review. Key search terms

Limiters: Published 1990-2012, English language, exclude dissertations, Peer reviewed.

Searches and search terms:

Search terms	Databases	Years
Ward environment & inpatient & outcome	EBSCO (PsychInfo and PsychArticles), SCOPUS, Medline and Web of Science	2000-2012
Ward environment OR atmosphere & outcome	EBSCO (PsychInfo and PsychArticles) and SCOPUS, Medline and Web of Science	2000-2012
Treatment environment & inpatient & outcome	EBSCO (PsychInfo and PsychArticles) and SCOPUS, Medline and Web of Science	2000-2012
Social environment OR climate & outcome	EBSCO (PsychInfo and PsychArticles) and SCOPUS, Medline and Web of Science	2000-2012
Ward environment OR atmosphere & satisfaction	Google Scholar	N/A
Ward atmosphere OR environment & aggression	Google Scholar	N/A

Appendix C
Data extraction pro forma

Article Number:		
Title:		
Author (1st only):		
Publication Date:	Place of publication:	
Journal:		
Volume:	Number:	Pages:
Keywords / Definitions		
Aims:		
Sampling / Participants: *(Total number of participants? Age range, diagnosis, type of ward, how was the sample recruited? Response rate?)*		
Study Type / Design: *(quantitative survery? Cross sectional or longitudinal? Qualitative interviews structured/unstructured?)*		
Measures: *(What measures were used?satisfaction or outcome measured? Are measures validated? At what time points are measures completed?*		
Analysis: *(What statistical methods were used? Descriptive stats? correlations? If quantitative what method of analysis used?))*		
Findings:		
Limitations		
Conclusions: (W*hat do the findings mean? Generalisability? Implications & Recommendations?)*		
Additional Comments:		

Appendix D
Methodological characteristics of the studies.

Author (s) and ID code	Aims of study	Methodology	Sampling &participants	Analysis/measures	Results	Reliability & Limitations
1. Rossberg et al (2006)	The aim of this study was to examine to what extent the different subscales of the Ward Atmosphere Scale (WAS) are related to patient satisfaction on wards for psychotic patients.	The environment of one acute psychiatric ward was evaluated 11 times during a 20 year period (1981-2000), The ward was rated once a year A total of 129 patients completed the WAS and three items concerning general satisfaction with the Ward.	129 patients participated. The range of collected forms varied from 27 in 1981 to eight in 1989 and 2000. The median number of collected forms was 11.5. No demographic information was collected about patients although roughly 70% of patients admitted to the ward during the study period	Mean and standard deviation scores were calculated for the 11 WAS subscales. These were compared with a sample comprising 54 wards from another study for patients with psychoses. included in the General Satisfaction Index (GSI). The Cronbachôs alpha for the GSI was Calculated (0.83). The patientsô mean s score for the GSI was also calculated. Correlations between the GSI scores and WAS	Four of the WAS subscales, strongly correlated with patient satisfaction. Unexpectedly, the Support and Order and organization subscales correlated only moderately with patient satisfaction. The remaining five WAS subscales correlated weakly with patient satisfaction.	Only one ward so ability to generalise results limited. Lack of information about participant characteristics and illness severity also limited study. Not known if sample was representative. Other changes to the ward may have influenced patient satisfaction during the period of study.

			were psychotic.	subscale scores were calculated as Pearson product-moment coefficients.		
2. Middelboe et al (2001)	Aimed to investigate the relationship between patients' perception of the real and ideal ward atmosphere and their satisfaction.	Patients filled in the Ward Atmosphere Scale (WAS, Real and Ideal Form) and a satisfaction questionnaire. Patient characteristics were derived from clinical assessments which included ICD-10 diagnosis, global assessment score (GAS), length of stay on the ward and use of medication.	101 patients participated from one psychiatric ward in Denmark. 80 patients were excluded either because they had signs of dementia or had been on the ward for less than 7 days. Among the eligible patients 56% consented to participate.	Measures included a Danish version of the WAS (WAS-R) and the WAS (WAS-I), to record patient's wishes as to the ideal treatment Environment. A five item satisfaction scale was developed from the Good Milieu Index developed (Moos, 1974). Paired and non-paired t-tests were used. Also a one-way ANOVA tested the differences between the diagnostic categories and questionnaire scores. Associations were	WAS ratings were almost independent of patient characteristics. Patient satisfaction was predicted by higher scores on the WAS. In particular support, order and organisation predicted satisfaction. patients gave the `ideal' ward higher ratings on most subscales.	Representative sampling was not achieved due to exclusion criteria. Some patients assisted by the staff to fill in the forms, which, influences patients responses and lead to a too positive picture of the ward.

				tested using Pearson's r and stepwise multiple regression. .		
3. Nesset et al (2008)	Aimed to explore whether staff training and lectures on milieu therapy to nursing staff can change patients perception of the ward environment and improve patient satisfaction.	The ward atmosphere was evaluated by patients and by staff before and twice after the staff training. Participants also filled the measures of satisfaction.	98 nursing staff and 29 patients participated from one forensic psychiatric hospital in Norway. There were no significant differences in age, gender, length of stay or diagnosis between the patients who participated and those who did not.	The revised WAS-R was used to measure ward environment and 3 items were used to assess satisfaction. Mean values and standard deviations were calculated for each of 3 times data was collected. Z scores were calculated and compared with a normative sample of 54 other wards in Norway.	Patients perceptions of the ward environment improves after the staff training on the majority of WAS subscales. Patient satisfaction also increased. Both changes were present 6 months after training.	The study included only a small number of patients from one ward. Not known if the sample was representative. The authors could not control for changes on the ward other than staff training that may have influenced patientôs responses to questionnaires.
4. Jorgensen et al (2009)	The aim of the study was to examine whether or not differences in ward atmosphere were associated	patients completed self-report measures 3 days after admission	Eighty patients from three different wards took part. 201 were	Self report measures comprised the WAS, a five-item index of patient satisfaction, the	The results showed that differences in the treatment environment between the	The study sample was small and unrepresentative. Only 39.8% of patients

	with differences in satisfaction and outcome.	to the ward unit and then again by the time of discharge. In addition, data for age, gender and length of stay were obtained from staff at the ward units as well as diagnosis according to ICD-10 (WHO 1992) and Global Assessment of Functioning (GAF) scores were obtained from the patientsô notes (American Psychiatric Association 1994).	considered eligible to participate. This meant a fairly low response rate of 39%. Comparison analysis revealed that the study sample did not differ significantly from other patients on the wards with respect to gender, age and length of stay, although there were slightly fewer patients with psychotic disorders in the sample.	Generalized Self-Efficacy Scale, an index of life satisfaction and the symptom checklist SCL-90R.Reliability testing for these measures was done by calculating Cronbachôs a. Treatment efficacy was calculated using paired samples *t*-tests. Differences between the ward means was done with a multivariate ANOVA. Results from this formed the hypothesis that patients on one of the wards would have more unfavourable outcomes compared with the other two which was tested using MANOVA	ward units were associated with differences in patient satisfaction. There was mixed evidence for associations between ward atmosphere and outcome , while no associations were found between ward atmosphere and self-efficacy and life satisfaction.	considered eligible for the study participated. A further number did not meet inclusion criteria. Only three wards studied so results may not be able to generalise to other inpatient settings.

				for repeated measures design.		
5. Rossberg and Friis **(2004)**	Aimed to examine the extent to which patientsô and staffôs perceptions of the psychiatric ward atmosphere and the working conditions of staff influence patient and staff satisfaction	Data was collected during the period 1990-2000 on 42 psychiatric wards in Norway. 640 Staff completed the WAS and the WES-10. 424 inpatients on the same wards completed the WAS. Each ward was rated only once and all the data were collected within five days on each ward.	Participants included 640 staff members and 424 patients from 42 wards. Most wards were short stay wards. All staff members (physicians, psychologists, nurses, and assistants) were included and were asked about the length of their employment on the ward. 43% had been working for more than three years.	Measures included the modified WAS-R and the WES-10 (self-report Questionnaire) to measure staff working environment on four subscales: self realization, work load, conflict, and nervousness. Both patients and staff responded to three questions developed by Moos (35) to capture general satisfaction: Non-paired t tests were used to analyze the differences between patientsô and staff membersô perceptions of the ward atmosphere and Pearson product-moment	Results showed ward atmosphere (patients WAS scores) to be strongly correlated with patient Satisfaction. Staff working environment (as measured by the WES-10) was not found to be related to patient satisfaction. Results also showed staff to have higher opinion of the ward atmosphere as rated by the WAS. scores	No information was collected about participant characteristics for example age, gender, length of stay. Or illness severity at the time of filling in the questionnaires. Not possible to say if the sample was representative or if results were bias towards better functioning patients. The satisfaction scale lacked reliability testing.

				coefficients calculated correlations between the WAS, WES-10 and satisfaction.		
6. Rossberg et al (2008)	Aimed to study the relationship between patient and staff satisfaction, and to study the relationship between staff working conditions and patientsô perception of the ward environment.	At 11 time points between 1981 and 2000, 129 patients completed ratings of the ward atmosphere and satisfaction and 359 staff completed ratings of perceived working conditions satisfaction. Z scores were calculated to describe fluctuations in scores during the study period	129 patients from one psychiatric unit in Norway? Participated. Roughly 70% of patients were psychotic on admission. No information about patientôs characteristics or diagnosis were collected. 359 day staff participated including nurses, doctors, psychologists and aids. The	Ward environment was measured using the WAS, satisfaction using the General satisfaction Index (GAS) and working conditions using the Working environment scale - 10 (WES-10). Psychometric properties of measures were not discussed. Z scores were calculated for ward averages of scores on each measure for each year between 1981 and 2000. This was compared to a normative sample of 54 psychiatric wards. Correlations	Results revealed that staff working conditions related to both patient satisfaction and patients perception of the ward environment. Authors concluded that staff working environment id important to the quality of care that patients receive.	Only one ward was study so generalisations are limited.. Due to lack of information about patients it is not known if the sample was representative. The study was limited generally in its reliance on self report measures which could not be validated.

			majority were nurses.	were calculated using Pearson product moment coefficients.		
7. Gilbert et al (2008)	Aimed to explore the inpatient experience in UK psychiatric hospitals.	Qualitative user led approach. 19 service uses took part. 10 of these were involved in an initial focus group and a further nine in unstructured interviews.	19 service uses who had had stays in over 10 different hospitals took part. Some had had a number of admissions over several years, and some had more recently inpatient stays for the first time.	Thematic analysis was used. Authors were open in their reporting of the analytic process. Member checking strengthened results.	Themes predominately referred to relationships on the ward as most important in shaping patients experiences. Relationships with other patients and staff were pivotal in how service usersô felt being on the ward.	Limited by the lack of a standardised way of measuring ward environment and patient outcome. Although themes alluded to areas of outcome they were talked about subjectively. Researcher bias was possible in formation of codes.
8. Bressington et al (2011)	Aimed to assess the levels of service user satisfaction in forensic inpatient settings and investigate the association between satisfaction and	A cross sectional survey design was adopted. 44 participants completed measures assessing service user	Forty-four service users participated. These were detained in 7 different secure settings in one UK, NHS	The EssenCES was used to measure social climate/environment of the ward. Satisfaction was measured using the Forensic Satisfaction Scale	Service usersô perceptions of the ward environment were associated with their levels of satisfaction. A	Only 40% of patients on the wards consented to take part which meant the sample was not representative. There was an over reliance on

	ward environment/climate and also perceived therapeutic relationship of the service users with their key-workers.	satisfaction, therapeutic relationships and the social climate of the ward. An independent researcher assisted participants complete the measures.	trust.	(FSS) (MacInnes et al., 2010), and perceived therapeutic relationship was assessed using the Helping Alliances Scale (HAS) (Priebe and Gruyters, 1993). All measures were reported to have good reliability and validity. Descriptive statistics were calculated and the Pearson correlations were conducted.	stronger association was found between service users perception of the therapeutic relationship and satisfaction..	self report measures Other variables not measured could have impacted on associations drawn between satisfaction, social climate and perceived therapeutic relationship.
9, Alexander (2006)	The study aimed to investigate the content of rules within acute psychiatric wards; to explore patientsô responses to the rules; to evaluate the impact of ward rules and rule enforcement on patient experience and nurseï patient	Mixed method approach. 30 patients took part in semi structured interviews and also filled in two questionnaires regarding ward environment and ward	30 patients and 29 staff participated from two psychiatric wards in the UK. Most patients had been on the ward more than two weeks. Diagnosis	The WAS was used along with the Hospital-Hostel Practices Profile (HHPP, Wykes *et al*. 1982) which asked patients what they believed the rules were. Quantitative data was analysed for descriptive frequencies, and t-	Quantitative results showed a difference between wards in terms of perceptions of environment and ward rules. Qualitative results revealed six themes where	Limitations included a small sample size which was not likely to be representative (this wasnôt stated). Generalisability was also limited due to the inclusion of only two wards. There

	relationships	rules. Non participant observation was also used to focus on staff-patient interactions in relation to ward rules.	varied between patients. The current paper reported on patient results only.	tests were used to compare means. Qualitative data was analysed using thematic and interpretative phenomenological methods.	patients spoke mainly negatively about ward rules. What emerged strongly was the importance of the way rules were enforced by staff.	was little explanation of how the author developed themes from qualitative data and no peer review of themes.
10. Gilbert et al (2010)	Aimed to explore patientsô subjective experiences of traditional psychiatric hospital stays and residential alternatives to hospital.	40 patients staying in residential alternative services who had had previous experience of admission to a traditional hospital took part in in-depth semi structured interviews.	Purposive sampling was used to recruit 40 patients from six residential alternative services. Services were identified as representative of the five different types of service identified by a national study of residential alternatives to	Thematic analysis was used for interview data. Themes were tested for validity through discussion ï in both one-to-one and group meetings ï by an interdisciplinary team comprising researchers with psychiatric, psychological and social work backgrounds	An overall preference for the environment of residential alternatives was expressed. The majority of themes in relation to this were within the context of a relationship. Half of participants stated ópeople make a placeô	No objective measure of environment. No information about patientsô diagnosis and other characteristics which may have influences their views. Also participants were interviewed while residing in hospital which may also have influenced their perspectives.

			hospital			
11. Osborn et al (2010)	Aimed to compare ward environment, patient satisfaction and perceived coercion in traditional psychiatric hospitals and residential alternatives. .	314 patients in total filled in questionnaires regarding ward environment, satisfaction and experience of admission. These were filled in close to the point of discharge.	314 patients took part (response rate was 70%). These were recruited from eight different type of service identified in a national survey to be representative of residential alternatives to standard acute hospitals in England	Measures included the WAS, the client Satisfaction Questionnaire (CSQ), the Service Satisfaction Scale ï Residential form (SSSï Res) and the Admission Experience Scale (AES).	Results showed that patients favoured alternative services in terms of their atmosphere, as revealed by WAS and AES scores. Patients from alternative services were also had significantly greater levels of satisfaction.	Results may not be generalisable due to the variability of alternative services. The sample may not have been representative. There was no information about patient characteristics. Results may also have been limited by patients completing them near to discharge.

Appendix E

List of the main themes developed by the researcher who carried out the psychodynamic observations to describe the ward

His first two themes were considered to be core anxieties underlying the other main themes. The other themes were described as defensive ways of coping as a result.

Themes one: óA problem with ôbeingô on the wardô

Theme two: óA longing for engagement despite difficultiesô

Theme three: óActivity as a defenceô

Theme four: óThe imposition of certaintyô

Theme five: óCare and controlô

Appendix F

Letter form local Research and Development committee approving the research

Research & Development Office
xxxxxxxxxx
xxxxxxxxx
xxxxxxxx

Direct dial: xxxxxxxxxxx
Email: xxxxxxxxxxxx

Tel: xxxx

27th March 2012

Katherine Foley
3 Chance Fields
Radford Semele
Warwickshire
CV31 1TR

Dear Katherine

RE: ***A qualitative exploration of participant's responses to feedback from a psychodynamic ward observation study (Supervisor: Dr.Arabella Kurtz).***

Thank you for supplying comprehensive details of the above-named study. I have reviewed the following documentation:

IRAS Form (Full Dataset)	20-02-2012
Investigator CV (Kath Foley)	Undated
Research Protocol	20-02-2012
Combined Information Sheet & Consent Form	Undated

I am happy to confirm that following changes to the GAFReC provisions in October 2011, research studies that only involve NHS Staff and have no other material ethical issues identified in research governance review, do not require review by an NHS Research Ethics Committee. I would suggest however, that, you should amend your Information Sheet and Consent form to include version numbers and dates to fit with legislative requirements.

This study falls within the latter definition, and as such, is formally approved to take place in xxxxxxxxxxxxxxxxx NHS Trust to further your studies for a Doctorate in Clinical Psychology. Please note, this permission does not oblige services and individuals on Beaumont Ward to take part in the study.

I am confident however that this study will provide very useful information, and I expect that you will have no issues in seeking participants.

Kind regards

xxxxxxxxxxxxxxxxx
[Associate Director of Research & Development]

Appendix G:
Chronology of Research Process

Summary of research activty	**Timescale**
Consult with academic supervisors and field clinicians	January- July 2011
Submit initial research proposal	May 2011
Meet with University Research committee panel	June 2011
Amend research proposal and focus on clinical placements. Complete IRAS form and prepare to submit to Research and Development Committee	July 2011- December 2011
Meet with the clinician planning to facilitate the away days and discuss initial plans for the day.	August 2012
Interview and pilot thematic analysis with Clinical Psychologist and Trainee Psychologist Complete literature review	August ï December 2012
Prepare for the away days. Hire audio recording equipment and test.	December 2012-January 2013
Attend away days. Audio record discussions. Observe and take notes.	31.01.13 and 01.02.13
Transcribe audio material from both days. Write up observation notes.	February 2013ï March 2012
Analyse data including data from evaluation forms	March ï April 2013
Begin writing research report going back to the data accordingly	May ï June 2012
Submit	May 2013
Prepare for viva	May ï July 2012

Appendix H:

Participant Information sheet

University of Leicester

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 agree 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 and if you have any further questions after reading, please feel free to contact me directly by phone or at the address provided. Please take your time to decide whether or not you want to participate.

Study Title

óQualitative analysis of staff responses to a formulation based upon a psychodynamic ward observation study'.

Primary Researcher: Katherine Foley, Trainee Clinical Psychologist, University of Leicester.

Address: School of Psychology, Clinical Section, 104 Regent Road, Leicester, LE1 7LT.

Contact: T. 0116 223 1639 E. kf89@le.ac.uk

Academic Supervisor: Dr Arabella Kurtz.: ak106@le.ac.uk

Purpose of the research

You may remember that a researcher came to observe your ward over the course of a few weeks in 2011 in order to learn more about the atmosphere of hospital wards catering for people with complex mental health problems.

The purpose of this research is to evaluate those observations. You will be invited to take part in a discussion about what was observed about the ward and your thoughts and opinions will be very valuable in evaluation process.

What will you be doing?

You will be invited to one of two away days (31st of January or 1st of February). As part of these away days ideas from the observation study will be shared by Dr xxxx. You will be invited to share your views and perspectives on these and to take part in an open discussion of how observations fit and compare with your experience of working on the ward.

The away days will be facilitated by Clinical Psychologist, Dr xxxx and will be designed to be safe and supported spaces where ideas can be exchanged freely.

What will this (feedback sessions) entail?

Each away day will start at 9:30 am and finish at 4:30pm. They will take place at the Department for Clinical Psychology at the University of é . Lunch will be provided

Dr xxx will support you to reflect on some of the challenges and demands of working on an acute psychiatric ward. Some of ideas that came out of observations of your ward will be shared and you will be invited to join a discussion and share your thoughts on this as far as you feel comfortable. The aim will be for day to be interactive so your ideas throughout the day will be very welcome.

Discussions during the away day will be audio recorded and transcribed by the researcher for analysis. Analysis of your views of the observations and how you experience what Dr xxxx offers will form an important part of the process of evaluating the original observational study.

The audio recordings will be stored securely at the Clinical Psychology department at the University of é and will be permanently deleted once they have been transcribed. The researcher will also attend the away day to observe and makes notes.

Confidentiality

It will be the researchers responsibility to ensure that anything discussed at the away day is confidential and that comments are not shared with anyone other than my Academic Supervisor. This will be important in order for the discussions to feel safe

Extracts from discussions at the away day maybe included in the final write up of the study however issues of confidentiality will be taken very seriously and audio recorded discussions will be treated in accordance with the Data Protection Act. This means that if a comment is included in the write up it will be assigned to a person with a pseudonym (fictitious name) in order to protect the identity of the speaker and the identity of anybody else he/she might talk about.

Additionally, an element of disguise may be used in the write up to ensure that any people or organisations are absolutely unidentifiable to anyone other than myself. My Academic Supervisor may read through some of the audio recorded material however once the research is over transcripts will be kept securely at the University of Leicester for a period of five years. It will be destroyed after that.

Any information that is kept on the computer will be password protected and only I will have access to it.

In the unlikely event that there are any concerns about any individual attending the away day, myself or Dr xxxxxx will deal with the matter as sensitively as possible. We will endeavour to discuss our concerns with you as appropriate before taking it any further.

What will happen if I agree to take part?

If you agree to take part you will be asked to sign a consent form, giving consent for discussion at the away day to be audio recorded.

Further information and the opportunity to ask questions will be scheduled into the day.

What will happen if I change my mind and don't want to participate?

Your participation is voluntary. If following the away day, you decide you would like to withdraw you can do this prior to the data analysis and deadline (April 2013). Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

Are there any risks in taking part?

No significant risks have been identified in this study. If, however, you feel you need further support during the process, myself, the researcher will be prepared to take action to make sure you are cared for. This may involve contacting your manager in order that appropriate support systems maybe put in place.

What are the potential benefits in taking part?

You will have the opportunity to share your views on the observations made of your ward last year and to have an active voice in evaluating these.

You will have the opportunity to talk about whether what was observed fits with your own experiences of working on the ward and discuss the things you were and were not able to recognise.

You may find it therapeutic to think in depth about your experiences of work and you may find discussions offer you an enriched perspective.

How will the findings of the study be used?

The final write up of the study will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this, it maybe published in a journal and be presented at a conference.

Who is funding the research?

The research is being funded by the University of Leicester and is sponsored by xxxxxxxxxxTrust.

Who had reviewed the study?

The proposed study has been reviewed and approved by a peer review panel at University of Leicester and by the xxxxxxxxxxxxxxxxxxxxxxxxxxxxx Trust Research and development committee.

Further Information

If you require any more information now or in the future you may contact the Primary Researcher, Katherine Foley.

THANK YOU FOR TAKING THE TIME TO CONSIDER PARTICIPATING

Appendix I:

Participant Consent form

Clinical Psychology Dept.
University of Leicester
104 Regent Road
Leicester
LE1 7LT
T: 0116 223 1639
F: 0116 223 1650

CONSENT FORM

Title of Project: ‘Qualitative analysis of staff responses to a formulation based upon a psychodynamic ward observation study'.

Name of Researcher: Katherine Foley, Clinical Psychologist Trainee, University of Leicester

Please read this consent form, and ask any further questions you would like to about what will be involved. Thank you.

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any point up to April 2013 without giving any reason. ☐
3. I understand that I will be attending an away day and that discussions during the away day will be audio recorded, and then transcribed. ☐
4. I understand that my identity will remain anonymous throughout the study and that if quotations are used from comments I make during the away day, my identity and the identities of other people I may mention will be protected by the use of codes. ☐
5. I understand that an element of disguise may be used in the write up of the study to ensure that any people or organisations are absolutely unidentifiable to anyone other than the researcher. ☐
6. I understand that if the researcher or facilitator of the away day is concerned about me they may want to take action to ensure I am cared for, but this will be discussed with me first. ☐
7. I understand that data from discussions during the away day will be kept securely at the University of Leicester and at the researcherôs home and will be destroyed after five years. ☐

8. I understand that data from the away day will be included as part of a thesis and submitted to the University of Leicester. It may also in the future be published and presented at a conference. ☐

9. I agree to take part in this study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix J:

Itinerary for the staff away days

Itinerary for away days

9:30 Arrival

9:30-9:45 Coffee

9:45 - 10:30 Introductions, hopes & aims

10:30-11:30 Taking stock: Feelings about the job - Group discussion & flip chart exercises

11:30-12:30 What is the job? (What is (are) the task (s)? & How do they support or interfere with each other. The task and the defences) - Group discussion & flip chart exercise

12:30-2:00 LUNCH

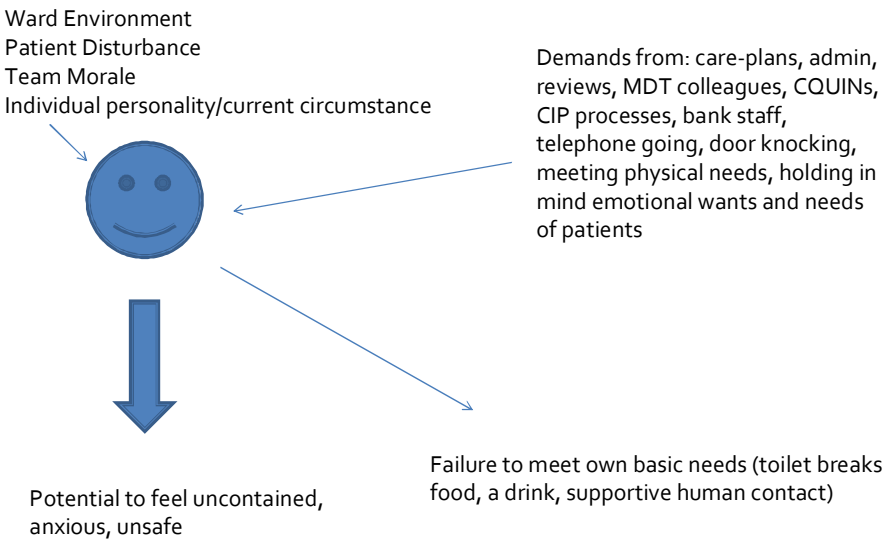
2:00-3:15 Taking what we did this morning and using Fionaôs research as a model for helping us fit it together. The development of a group formulation/understanding assessing the experience of the ward staff and the potential effect on patients. Ruth delivering model/formulation and interactive drawing.

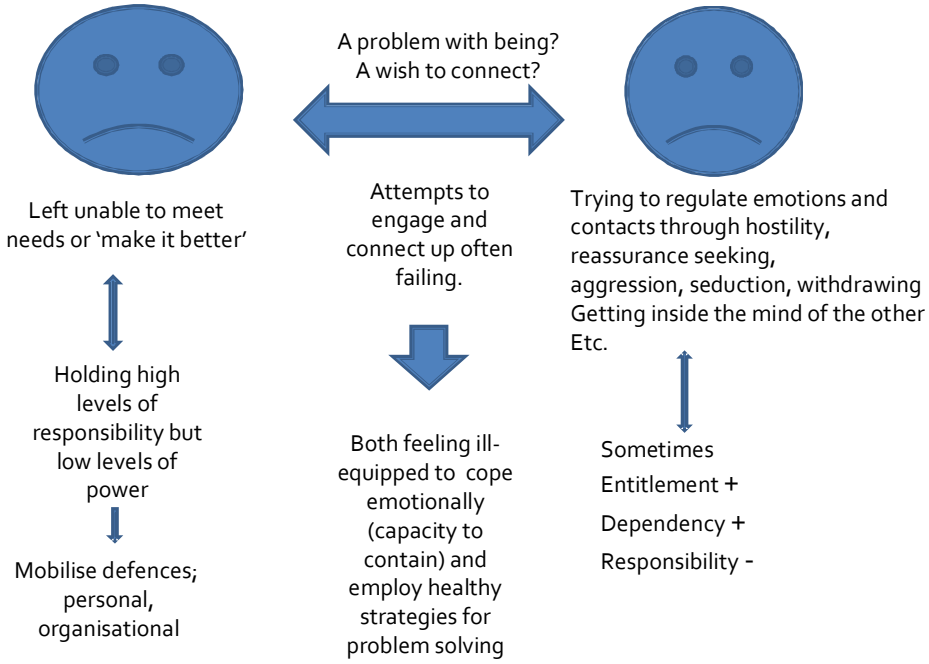
3:15- 4:00 What does the formulation mean? How do we engage with it? Ways to move forward; personally? as a team? for the ward? and for the organisation? Making some commitments.

4:00-4:30 Evaluation. Questionnaire by current researcher

Appendix K

Slides from the power presentation shared with staff during the away days


Ward Environment
Patient Disturbance
Team Morale
Individual personality/current circumstance
Demands from: care-plans, admin, reviews, MDT colleagues, CQUINs, CIP processes, bank staff, telephone going, door knocking, meeting physical needs, holding in mind emotional wants and needs of patients
Potential to feel uncontained, anxious, unsafe
Failure to meet own basic needs (toilet breaks food, a drink, supportive human contact)

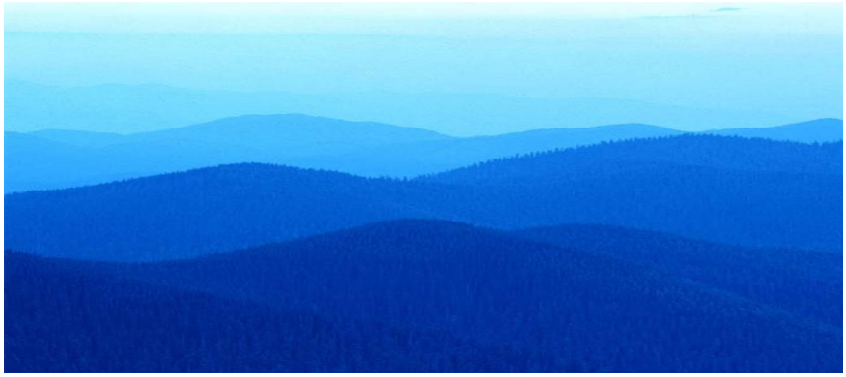

A problem with being?
A wish to connect?
Left unable to meet needs or 'make it better'
Attempts to engage and connect up often failing.
Trying to regulate emotions and contacts through hostility, reassurance seeking, aggression, seduction, withdrawing
Getting inside the mind of the other
Etc.
Holding high levels of responsibility but low levels of power
Mobilise defences; personal, organisational
Both feeling ill-equipped to cope emotionally (capacity to contain) and employ healthy strategies for problem solving
Sometimes
Entitlement +
Dependency +
Responsibility -

Defences

Examples?

- Acting in a role
- The nurses office, the table
- The problem & solution of 'activity' and 'action culture'
- Depersonalisation of self and others
- Engaging in a safe way – but does it meet the need?
- Projecting responsibility?
- 'Please don't tell me'

Defences are not bad

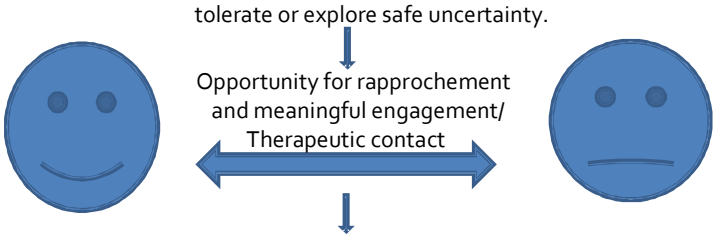


Just need to be aware and curious about self and others
'A state of mindfulness'

Bringing defences into conscious awareness

Creating safe space inside and out
and validating experiences/feelings and thoughts

Opens up opportunities to employ different coping strategies, relocate problems and assert personal agency with self and others and thereby tolerate or explore safe uncertainty.



Opportunities for healing and change

Appendix L:

Evaluation form for the staff away days

Thank you very much for taking the time to fill in this brief questionnaire.

Please state how much you agree with the following statements. Responses are anonymous.

What are your initial reactions to todayôs away day?

During the day I have felt and been able to share my views and perspectives

Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree

I could relate to the ideas discussed in the formulation and felt they were relevant to my job

Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree

I have found the discussions valuable for reflecting on what goes on on the ward.

Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree

Today has helped me think about my practice in a different way

Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree

Was there anything you felt unable to share or did not have time to share?

Any other Comments?

Thank you very much for contributing to the day

Appendix M:

The researchers epistemological position

Epistemological Position

Reflexivity is important to consider in terms of the authors position and the impact she has on the research and vice versa (Morrow, 2005). The epistemological stance adopted by the researcher in the current study was most closely aligned to a critical realist position which combines aspects of constructionist and realist positions (Sims-Schouten et al., 2007**).** The researcher believed that what was said by participants during the away days had some significance and reality for them beyond the bounds of the discussion but that a version of reality was co-constructed between them through their interactions. Equally she acknowledges that the interviews did not reveal an existing ñrealityò (Murphy & Dingwall, 2003, cited in Charmaz, 2009) but rather an understanding of this created between the participant and researcher. She understood that participants represented in part a manifestation of their psychological world, whilst being connected also to the world outside and the (Smith, 1995).

The researcher had worked previously as a health care assistant in a psychiatric ward. She had found this to be an intense and challenging environment and was aware of the impact of this experience on what she considered to be the órealityôof the ward thought about in the current study.

References

Charmaz, K. (2009). *Constructing grounded theory: A Practical Guide Through Qualitative Analysis.* **Sage Publications**.

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**

Smith, J.A. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre, & L. Van Longenhove (Eds.) *Rethinking methods in psychology*. **London: Sage.**

Sims-Schouten, W., Riley, S.C.E., & Willig, C. (2007). Critical realism in discourse analysis. A presentation of a systematic method of analysis using women‟s talk of motherhood, childcare and female employment as an example. *Theory and Psychology, 17,* **101-124.**

Appendix N

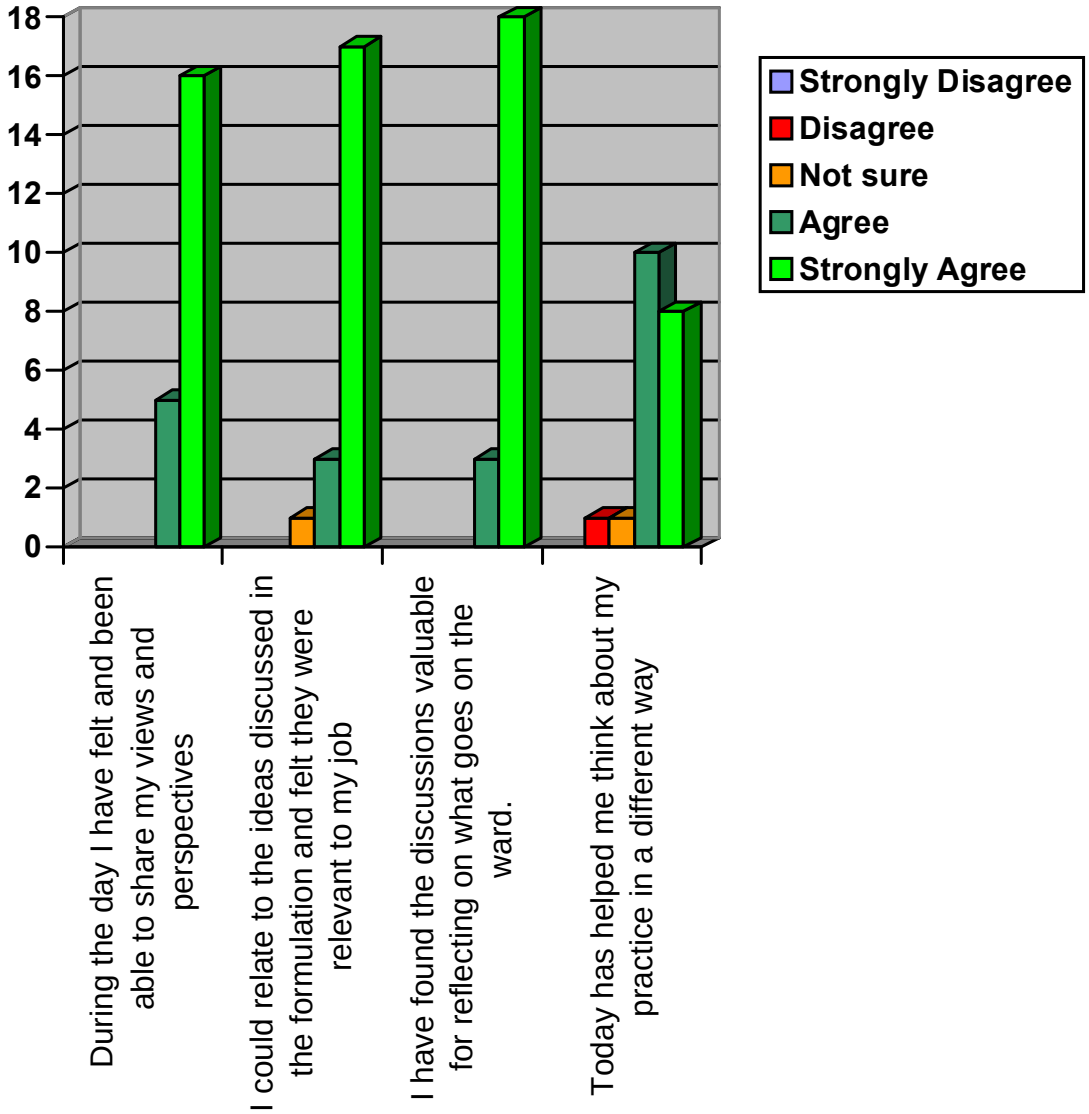
Results from the staff evaluation from

Results from the staff evaluation from

Twenty one members of staff filled in the evaluation forms over the two days.

Quantitative results

Overall, quantitative responses about the day were generally positive with the largest number of staff responding with ôstrongly agreeô or ôagreeô to most questions asking them how they had found the day and what they had gained. Figure 2 shows the collated responses of all questionnaires from both days.



Qualitative results

Qualitative data from the evaluation form provided further information about staffs response to the two days. Three open ended questions explored staffsô response anonymously. These were analysed thematically.

Eight members of staff commented on the first question. The open coding revealed four common themes and frequencies for each theme are outline in the table below.

Results indicated that staff felt positively about the day, that it was over due and that it was a good opportunity to reflect. Staff also appreciated being listened to.

Table 3: Thematic results for question one from the staff evaluation form

What are your initial reactions to todayôs away day?	
Theme	**Number of comments in this theme**
A: Long over due	2
B: Good opportunity to be think constructively	3
C: Brilliant	2
D: good to be listened to	2

Eighteen people commented on the second question. Analysis revealed four predominant themes.

Table 4: Thematic results for question two from the staff evaluation form

Was there anything you felt unable to share or did not have time to share?	
Theme	**Number of comments in this theme**
A: No	7
B: I felt able to share everything I wanted to	5
C: It was a valuable	2
D: Unable to support patients when they need help	1

Eighteen people also commented on the third question. Analysis revealed four predominant themes.

Table 5: Thematic results for question three from the staff evaluation form

Any other comments?	
Theme	**Number of comments in this theme**
A: Have away days like this more regularly	6
B: Thank you for the day	4
C: The facilitator is very supportive	3
D: The research was hard to follow	1