

The experiences of inpatient nursing staff caring for young people with early psychosis

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ABSTRACT

Background

Early Intervention services aim to improve outcomes for people with first episode psychosis, and where possible, to prevent psychiatric hospital admission. When hospitalisation does occur, inpatient staff are required to support patients and families who may be less familiar with services, uncertain about possible outcomes, and may be experiencing psychiatric hospital for the first time.

Aims

Our study aimed to understand the process of hospitalisation in early psychosis, from the perspective of inpatient nursing staff. We were particularly interested in their experiences of working with younger people, in the context of adult psychiatric wards.

Methods

Nine inpatient nursing staff took part in semi-structured interviews, which were transcribed, and then analysed using Interpretative Phenomenological Analysis.

Results

Five themes are outlined: *“It’s all new and it’s all learning”*; *The threatening, unpredictable environment*; *Care and conflict within the intergenerational relationship*; *Motivation and hope*; and *Coping and self-preservation*.

Conclusions

The phenomenological focus of our approach throws the relational component of psychiatric nursing into sharp relief. We reflect upon the implications for organisations, staff, families and young people. We suggest that the conventional mode of delivering acute psychiatric inpatient care is not likely to support the best relational and therapeutic outcomes.

Keywords: phenomenology; young adult; inpatient; psychosis; burnout; hope; acute care.

Psychosis most often develops in late adolescence and early adulthood (Harrop & Trower, 2001). Psychotic symptoms are heterogeneous, and their causes are likely to be complex (Radua et al., 2018). Early Intervention Services (EIS) offer a range of biopsychosocial interventions to young people (age 16-35) with psychosis, during the ‘critical period’ after first onset (McGorry & Jackson, 1999). EIS aim to foster recovery and prevent admission to psychiatric hospital. Nevertheless, in some cases hospitalisation may be required. This can be a negative, or even traumatic, experience for service-users (e.g. Berry, Ford, Jellicoe-Jones & Haddock, 2013; Morrison, Bowe, Larkin & Nothard, 1999). These young people, who have often been hospitalised for the first time, and possibly without previous contact with mental health services, are likely to have distinctive needs (Islam, 2011). It is crucial that they have positive experiences of inpatient care in order to reduce the risks of both traumatisation, and subsequent disengagement from mental health services. Nursing staff play a key role in ensuring the quality of that care (McDougall & Sanderson, 2016), but evidence suggests that acute care practices with young people may be poorly evidenced (Dusseldorp, Goossens & Achterberg, 2011), and are generally non-standardised (Puyat et al., 2017). There is very little literature which provides evidence for best practice, however. To some extent this is because researchers in early psychosis care have focused on the use of *acute* care as a negative outcome, rather than as part of the process of supporting young people’s recovery. A recent major review of first episode psychosis care only mentions hospitalisation as an outcome, for example (Fusar-Poli, McGorry, & Kane, 2017), whereas it provides comprehensive discussion of a range of other services and interventions.

When we consider the quality and appropriateness of the care offered to young people with psychosis on adult inpatient wards, we must also consider staff’s capacity to deliver such

care. The generic literature on workplace burnout identifies a number of risk factors for staff, which include roles demanding high empathy, and providing low control, in contexts which provide limited access to relevant support mechanisms (such as team meetings or clinical supervision). In acute inpatient environments, many of these conditions are likely to be met (Richards et al., 2006) particularly if the presence of younger people evokes empathy (e.g. see Odeyemi, Morrisson & Donohue, 2018). Pressures on inpatient environments in mental health services (e.g. Mind, 2004; 2011; Garcia, Kennett, Quarishi & Durcan, 2004; Keown, Weich, Bhui & Scott, 2011) contribute further to those factors associated with pressures on time and resources; the perceived vulnerability of young people may also raise the stakes. High exposure to burnout conditions has been shown to have a direct impact on the wellbeing of nursing staff (e.g. Zhang, Loerbroks & Li, 2018) and to undermine the effectiveness of organisations.

In the context of this knowledge, our paper seeks to better understand the experiences of inpatient staff working with young service-users with early psychosis through the detailed examination of their experiential accounts. It forms part of a larger multiple perspectival study on the experience of hospitalisation in early psychosis. Analyses of the accounts of young people (Authors, 2014) and parents (Authors, 2015) have been published elsewhere. Multiple perspective studies are a relatively novel form of design, which can increase the ‘inferential range’ of interpretative phenomenological studies (Larkin, Shaw & Flowers, in press). In this paper, we present one standalone component of a multiple perspective study.

METHOD

Approach

Interpretative Phenomenological Analysis (IPA) is a qualitative method concerned with understanding the meaning and context of salient experiences (Smith et al., 2009). IPA balances a phenomenological commitment to understanding the experiential claims and concerns of research participants, against a more hermeneutic emphasis on the researchers' role in making sense of the patterns within participants' accounts. It also maintains a commitment to an idiographic level of detail, and consequently requires rich data from relatively small numbers of participants in clearly defined contexts.

Participants

A small, purposive, homogenous sample was used, in accordance with IPA principles, which prioritise the case-level 'depth' or 'richness' within a data set (Smith, Flowers & Larkin, 2009). Nine inpatient staff, who had all worked with EIS-users in the last twelve months, were recruited from two adult acute inpatient units in a large NHS Trust. The Trust covered both rural and urban areas. The sample included qualified and unqualified nursing staff (three nursing assistants, six registered Mental Health Nurses) each with a minimum of 1.5 years of prior inpatient experience. Four participants also had ward management responsibilities (manager or deputy manager). All participants provided informed consent.

Data collection

The first author conducted all interviews. Access, and clinical supervision for the interviewee, were provided by the third author. Interviews explored staff members' roles,

and their experiences of working with younger people. Interviews were anonymised at the point of transcription. Pseudonyms are used throughout this paper.

Data analysis

Coding and thematising in IPA are based upon a set of underlying principles (see Smith et al., 2009) which involve movement (in coding) from the descriptive to the more explicitly-interpretative, (in focus) from the specific to the thematic, and (in organisation) from the case to the wider sample. The first author initially worked transcript-by-transcript, coding data line-by-line, to note the experiential concerns (see Larkin & Thompson, 2011) of each participant. Emergent themes were identified through identifying and exploring patterns of meaning associated with these concerns. Once themes were developed for each transcript, a cross-case analysis identified one set of super-ordinate and sub- themes for the whole data-set. Peer comparison of this analysis was conducted with the fourth and fifth authors. An experienced IPA supervisor (last author) monitored the audit trail and oversaw the analysis. Further refinement of the analytic work was conducted when the themes were reviewed in the context of the two related components of the larger study (interviews with young people, and with parents). Further refinements were made, in light of this overview, by the second and last authors.

ANALYSIS

Five super-ordinate themes were developed. These are: *“It’s all new and it’s all learning”*; *The threatening, unpredictable environment*; *Care and conflict within the intergenerational relationship*; *Motivation and hope*; and *Coping and self-preservation*.

“It’s all new and it’s all learning”

Participants talked about how they were initially uncertain about what constituted the young person’s distress because, unlike many older service-users, there was a lack of precedent for the young person’s encounter with the inpatient environment. Without holding prior knowledge about the service-user, staff felt that everything was unpredictable. Participants believed that the young people also struggled with this lack of precedent. Without the service-user having insight into their situation, the staff believed they were likely to be readmitted. The idea that each case was therefore very different surfaced throughout the accounts:

“Someone with a long history you can almost, you can read back in the notes and there’s- there’s a pattern, but obviously with the young ones, this could be new, you know, we don’t know what’s causing it [...] so it’s all new and it’s all learning.”

(Heather)

“Some people can be withdrawn, some people can- as soon as they come on the ward, some people can be quite violent. We have to deal with each situation that comes up really, you know, some people react differently.” (Sue)

Staff also spoke of their sadness here that many younger service-users are admitted and then later readmitted. It was not evident that participants would learn about service-users' trajectory after acute care *unless* they were ever readmitted. As a consequence, they were often pessimistic about the chances of remission or recovery – the sense of psychosis as a tragedy (of curtailed or unfulfilled potential) was echoed in the repetition of language like '*dreadful*' and '*sad*,' when staff described their role.

The threatening, unpredictable environment

Participants described the ward itself as threatening, potentially violent, and non-therapeutic, contradicting the ideal of hospital as a place of help and safety. The physical environment was seen as potentially detrimental to service-users' health, with "*dark, horrible rooms*" (Linda). The unit was seen as unfit for younger service-users:

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

Several participants expressing this view, suggesting that whilst hospital admission could sometimes help, being in this environment could be detrimental, and might sometimes inhibit recovery.

In general, participants' work was described as reactive, rather than proactively planned in response to a service-user's needs. Each situation was dealt with as it arose, creating an unpredictable working day:

“Because every day, every hour is totally different, we could have a ward that's settled and then it just escalates. One person will, say, be violent, then another person - it just, I don't think you get time to cope you just- you just get on, to be honest with you, I mean you could go and find someone hanging, in a room, and then five minutes later, you're making beds, you know, it's just, the whole, the whole shift, you can't ever plan anything.” (Sally)

Here, there is a sense of urgency in how the escalation of violence is described, and something ‘contagious’ is implied in the way that Sally describes the risk of violence escalating. Several participants characterised the wards as environments which needed order and stability, and yet were difficult to control. Most participants commented on the anxiety arising from the perceived the risk of violence between service-users and towards staff. Many spoke of aggression as inevitable, given that service-users are *“acutely unwell”* (Karen) and yet expected to tolerate each other. They described how aggression towards staff was something one learned to accept over time, suggesting that being a target for aggression is ‘part of the job’. The stark contrast between finding *“someone hanging”* and then *“making beds”*, in Sally’s account, is jarring. It resonated with similar, but less dramatic, statements made by other participants, which highlighted how little opportunity there was to reflect on disturbing events. The threat of dehumanisation or desensitisation, is evident.

Care and conflict within the intergenerational relationship

All participants talked about how they related to the young service-users. Some felt that it could be difficult to get on with younger people, others described how they became emotionally involved.

All but one participant likened their role with younger service-users to that of a parent, either feeling more emotionally attached to them, or seeing themselves as a role-model:

“I treat them like my own, to be honest with you. One of them said to me the other day, ‘You’re like my bloody mother you are’, er, and I said, ‘Well, you know, I’m trying to be, but it’s only trying to guide you kind of thing.’” (Janet)

Despite this desire to form relationships with the young people, most participants also described feeling limited in the extent to which they *could* get involved. Most felt that acute care was limited to managing emergencies, with service-users only admitted for short times, thus restricting their ability to form strong therapeutic relationships with the young people:

“[We] get them to a point where they’re stable enough, but we never get to do the long term work.” (Heather)

Participants remarked that they had to accept this limited role because of a wider belief that inpatient care no longer involved working therapeutically. Many participants expressed their preference for developing relationships with the young people, but pointed to administration workload as an obstruction to spending more time with service-users.

Motivation and Hope

Staff were highly motivated to work with service-users experiencing early psychosis. They described how it was important to ‘catch them early,’ in order to prevent further admissions. Staff attempted to spend more time with younger service-users, in spite of the challenges:

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

Working with young service-users introduced the possibility of hope; most participants felt there was more chance of helping someone if they were in the early stages of psychosis:

“You are kind of hopeful that you've done something, you've made a difference, you've helped, and you'll never see them again - they're- they're going to recover and go on to erm, you know, have a decent life [...] and hopefully not be in and out of hospital for the next twenty years.” (Kim)

In contrast, Kim described working with longer-term service-users as “*thankless*”.

Working with younger service-users seemed to offer a chance to make a difference and hope for recovery.

Coping and self-preservation

For most participants, ‘getting on with it’ was the default way of coping, in the absence of an alternative. Views of support differed; some felt that it was available but were unable to ask for it, others felt they needed more support:

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

Staff sometimes faced extreme situations involving young service-users, which were subsumed as ‘part of the work’ rather than as something that required support. There were limited opportunities to reflect on these experiences. However, some participants did not recognise a need for any support; for example Janet stated, *“I don't need support! I am here to work [...] it's a job!”* All participants described working as a team, and most said that sharing concerns and frustrations with each other was necessary to *“survive in this job”* (Sam).

Despite their desire to develop relationships with young service users, staff thought it necessary to detach themselves from their work, and from individuals:

“As a student when I looked at these people that were cynical and seemed burnt-out or didn't seem to care ... it's self-preservation [...] it's about learning to detach

that bit more and to not get so involved and frustrated at things that you can't change.” (Kim)

Here Kim suggests that it is necessary to become detached in order to cope with the frustration of not being able to influence change. These feelings of impotence contrast with the hopefulness experienced around making a difference for younger service-users, and point to the tensions inherent in caring for young people with psychosis.

DISCUSSION

This study forms part of an innovative, larger multiple-perspective study, with other components already published (Authors; 2014; 2015a; 2015b; 2017). Our analysis here suggests that staff find acute inpatient work both stressful and distressing, and this is consistent with findings from other studies of acute mental healthcare workers (Cleary, 2004; Hummelvoll & Severinsson, 2001). However, we have focused specifically on staff's experiences of working with younger people experiencing early psychosis. It is clear that such work brings additional challenges and rewards, and that these merits further consideration. It is also clear that – in the context of the wider multiple perspective study - staff concerns are aligned with those of young people (Authors, 2014) and their family members (Authors, 2015) when it comes to both *the importance of relationship-building*, and the *distressing nature of the inpatient environment*.

In terms of the distressing nature of the inpatient environment, staff described the unit as unpredictable, chaotic and threatening, and felt it was neither a suitable nor therapeutic environment for young people, to the extent that it could 'make them worse'. Staff reported feelings of hopelessness, impotence and frustration, along with a constant state of high arousal in response to the threatening environment. Aggression was normalised as 'part of the job', yet evidence suggests that violence towards staff predicts poorer quality of care (Arnetz & Arnetz, 2001) and can result in post-traumatic stress disorder for some staff (Richter & Berger, 2006). These concerns about the environment were mirrored in Authors (2014), where the young people described how the wards could feel *unsafe* and *chaotic*. In Authors (2015a), family members initially expressed relief at the apparent safety and respite offered by hospital – but then described *feeling let down by services*, when they felt excluded from the young person's care.

With regard to relationship-building, staff in this study found that young service-users challenged their boundaries, both in terms of their potential hostility, and their vulnerability. In the context of the environment described by staff in this study, and the wider literature (e.g. see the review by Staniszewska et al., in submission), we might expect young people to be frightened, distressed and sometimes angered by their situation. Anger and distress may also be indications of a young person's attempts at managing attachments, in response to anxiety about their illness and admission (Adshead, 1998). Between 40-50% of young people with psychosis have a history of abuse and trauma (Schäfer & Fisher, 2011) and therefore have an additional risk of insecure attachment patterns. This has implications for *how* they are cared for during hospitalisation, and by *whom*. Studies have demonstrated that mental health services can have a positive influence on the attachment style of service-users by providing a secure attachment figure (e.g. a named worker), and that service-users may have less anxious and avoidant attachments to named workers in comparison with their general relationships (Adshead, 1998; Arbuckle, Berry, Taylor & Kennedy, 2012; Berry, Wearden & Barrowclough, 2007). The best way to facilitate positive relationships and reduce behaviour patterns staff find challenging (anxious help-seeking/hostility) may be to ensure that service-users are given plenty of opportunities to develop a good relationship with a named nurse during their admission. The challenges to such relationship-building are primarily from the increasingly *short-term* nature of any relationships formed in these environments, and given the pressures on the environments and the power dynamics within them, the sense that they are not *conducive* to trust and reciprocity. Nevertheless, in Authors (2014), young people commented on the role played by infrequent but significant moments of connection made with others. One key challenge for services is to enable staff to make more of these connections.

In contrast to the hopelessness associated with service-users with more established illness patterns, staff working with young people with psychosis experienced increased hope, emotional attachment, and opportunities for accomplishment. There is little research on the factors that contribute to hope in mental health nursing, and more is needed (Cutcliffe & Koehn, 2007). However, it may be that this optimism relates to the hypothesised ‘critical period’ in psychosis, during which it is thought possible to influence prognosis (Birchwood, McGorry & Jackson, 1997). Supporting hopefulness (perhaps by providing staff with more information and positive feedback about *good* outcomes) might be an important strategy for protecting against burnout and allowing inpatient teams to sustain an empathic stance towards service-users.

In some instances, the difficulties associated with caring for young people with psychosis in this environment resulted in avoidant coping-strategies. Avoidance may be one way in which staff attempt to protect themselves from being overwhelmed by difficult feelings evoked by their work. This research described ways they *consciously* detached and ‘got on with it’, but the theory of social defence systems (Menzies, 1960) suggests that staff may also *unconsciously* defend against their anxieties by blaming restrictions on service-user contact (such as increased paperwork) for their avoidant behaviour. Avoidance increases physical and psychological distance, destabilising young service-users’ attachment attempts and minimising opportunities for therapeutic interaction, which could provide a buffer against the chaotic environment. Staff in this study recognised that opportunities to interact therapeutically were lacking. They also recognised that the organisational narratives about ‘coping well’ did not include the routine use of clinical supervision or formal team and peer support. Given that the wellbeing of staff and patients are linked by

the capacity to provide good care and a safe environment, organisations providing acute inpatient care need to be mindful of these pressures upon staff, and to provide effective supervision (Brunero & Stein-Parbury, 2008; Buus & Gonge, 2009; Hyrkäs, 2005; McCarron, Eade & Delmege, 2018). It is important to foster cultures which both provide appropriate support and which enable staff to access that support. Organisational procedures, training programs, and funding streams, which encourage service-providers to ‘think relationally’ would help to promote this culture change. Processes and activities which promote genuine, meaningful ways of interprofessional collaboration may also be helpful.

Implications

In typical, ‘single sample’ design IPA studies, the context-specific nature of the analysis is a limitation which is typically traded off against the benefits of in-depth insights. In this study, we are further supported by the consonance between staff concerns and those of young people and parents in our previous studies. Our multiple-perspective research programme shows that inpatient staff experiences mirror those of EIS-users (*Authors*, 2014) who find hospitalisation distressing, and the inpatient environment to be chaotic. Parents (*Authors*, 2015a) also find the early stages of psychosis and its treatment bewildering. Combined together, these findings imply that young people and their families need better support during crisis care. One way to achieve this is by providing space, time and support for staff (including supervision, support and training), helping them enhance therapeutic relationships with service-users and carers, and to cope with the impact of working in a challenging inpatient environment. It is by no means clear that crisis care services as they currently configured are best placed to provide this (e.g. see Birchwood & Singh 2013; Gilbert et al., 2010; McGorry, 2009; Papoulias et al., 2014; Staniszewska et

al., in submission). Alternative models might be tailored to young people, and more accessible for friends and families, for example. They might provide this via a crisis or respite house, rather than a hospital.

All participant groups in each of our three studies emphasised the importance of relationship-building (trust, communication, connection) in order to support recovery. In acute care environments, the significance of relationships can sometimes be lost, or demoted to a secondary position, because of the sense of urgency and crisis. Our studies underline that relationships are often a primary component for mental health recovery, but also show that healthcare organisations and systems can obstruct their development.

Key points

1. Staff delivering inpatient psychiatric care experience the work as stressful and unpredictable, and the environment as threatening. In this study, participants' preferred coping strategies appeared to be amongst those which are generally considered to be less helpful. Organisations which provide such services should provide consistent access to good quality clinical supervision.
2. Staff are aware of some of the distinct vulnerabilities and different needs of younger people in this environment. They are motivated to 'make a difference' for young people, particularly through relationship-building. The structure of the environment, and their role within it, appears to obstruct this. Organisations which provide acute psychiatric care services for young people should design systems and environments to meet young people's needs, and which do not expose them to further fear and distress.

3. Staff in these environments should be supported in developing evidence-based, short-term interventions. We would suggest that core therapeutic skills such as listening, trust-building and relationship-development should be at the core of these interventions.

Ethical permissions

The research received ethical approval from the UK health service's National Research Ethics Service (NRES), via a full review from the Birmingham East, North and Solihull Research Ethics Committee (Reference 10/H1206/15).

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