A Thesis Submitted for the Degree of PhD at the University of Warwick

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Experiences of inpatient settings: Eating disorders and deliberate serious self-harm

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This thesis is submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

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May 2020

Contents

List of appendices

List of abbreviations

ACT	Acceptance and commitment therapy
AN	Anorexia nervosa
ARFID	Avoidant restrictive food intake disorder
AST	Analytical subtheme
AT	Analytical theme
BN	Bulimia nervosa
CF	Compassion fatigue
DSSH	Deliberate serious self-harm
DT	Descriptive theme
ED	Eating disorder
EDNOS	Eating disorder not otherwise specified
HCASW	Healthcare assistant/support worker
HCS	Healthcare service
IPS	Inpatient psychiatric services
KST	Key search term
MDT	Multidisciplinary team
MHCS	Mental healthcare service
OSFED	Other Specified Feeding or Eating Disorder
TS	Thematic synthesis
UFED	Unspecified Feeding or Eating Disorder

Declaration

This thesis has not been submitted for any other degree or to any other institution. The thesis was conducted under the academic and clinical supervision of Dr Jo Kucharska (Clinical Psychologist; Coventry University), Dr Sarah Simmonds (Clinical Psychologist; Coventry University), and Dr Mandi Hodges (Clinical Psychologist), all of whom were involved from the initial formulation of the research idea and design. All of the material presented in this thesis is my own work.

The literature review is written for submission to the Journal of Eating Disorders. The empirical paper is written for submission to the Journal of Psychiatric and Mental Health Nursing.

Summary

This thesis explores the views and experiences of inpatient treatment interventions of people with eating disorders, and healthcare support workers' experiences of witnessing and responding to serious deliberate self-harm. Chapter 1 is a systematic literature review. It critically evaluates qualitative research exploring adults' experiences of receiving specific, named treatment interventions, delivered across multidisciplinary professions, for eating disorders in inpatient treatment services. Following database searches, 11 studies were identified for inclusion in the review. Eating disorder inpatients described inpatient interventions as facilitating a journey towards self-connection, comprising regaining a healthy autonomy, awareness and acceptance of their cognitions and bodies, and connection with other people. Thus, these services might facilitate the individual inpatients' journey to self-connection. This could be achieved through consideration of each individual inpatient's experience from admission to recovery in relation to their individual needs, motivation and readiness to change.

Chapter 2 is a qualitative research study. Using interpretative phenomenological analysis, the lived experiences of healthcare support workers, witnessing and responding to their first few incidences of deliberate serious self-harm, are explored. The healthcare workers have had up to their first four months working on inpatient psychiatric service wards. Findings revealed two superordinate themes: 'connection to the horror' and 'power'. 'Connection to the horror' describes how healthcare support workers journey to connect to the reality of their role through hearing colleagues' accounts about previous deliberate serious self-harm incidences, and directly witnessing and responding to their first few incidences of deliberate serious self-harm. 'Power' describes dichotomous perceptions of who were perceived by healthcare support workers to hold power on the wards, and how this informed dichotomous responses during deliberate serious self-harm incidences, as well as the power of responding to deliberate serious self-harm as a staff team. Findings could inform how healthcare services support staff cope with their new roles, reducing burnout, sickness absence and high attrition rates, while promoting staff wellbeing and compassionate care.

In Chapter 3, the acceptance and commitment therapy approach is used to formulate personal reflections, in the form of thoughts, memories, emotions and physiological sensations, arising during the research. These reflections are reflexively evaluated and emerging themes around containment are discussed. *Overall word count: 20164.*

Chapter 1

Systematic Literature Review

Views and experiences of inpatient treatment interventions of people with eating disorders: A systematic literature review

Written in preparation for submission to the Journal of Eating Disorders (see Appendix A for author instructions for submission)

Overall chapter word count: 8204 words

1.0 Abstract

Aims: This systematic literature review aims to critically evaluate the qualitative research exploring adults' experiences of receiving specific, named treatment interventions, across multidisciplinary approaches, for eating disorders in inpatient treatment services.

Method: PsycINFO, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science, Scopus, Google Scholar and ProQuest Dissertations and Theses were searched to identify relevant literature. Eleven studies were identified as meeting the inclusion criteria of studies published during or after 1995, exploring the lived experiences of adults, regarding a specific, named inpatient intervention (previously received, or currently receiving) for the treatment of an eating disorder.

Findings: Thematic synthesis revealed an overarching theme that inpatients being treated for eating disorders experienced interventions as an increasing 'connection to self'. Three analytical themes emerged: (1) 'connection to control'; (2) 'connection with internal experience'; and (3) 'connection with others', each with analytical subthemes.

Conclusion: Inpatients experienced the inpatient interventions as facilitating a journey towards self-connection. This comprised regaining a healthy autonomy, awareness and acceptance of their cognitions and bodies, and connection with other people. Therefore, interventions provided in inpatient treatment services for eating disorders could facilitate inpatients' journey to self-connection. This involves considering each individual inpatient's needs, associated with their admission and recovery stage, their motivation and readiness to change. This is especially important when considering the appropriateness of intervention types and formats, whether individual or group. The limitations of the review and future research directions are discussed.

Keywords: *eating disorders, inpatient, treatment, intervention, experiences, qualitative, review.*

<center>**1.1 Introduction**</center>

Eating disorders (EDs) are complex, biopsychosocial diagnoses, characterised by enduring, problematic behaviours around feeding and/or eating (Diagnostic and Statistical Manual of Mental Health Disorders-Fifth Edition [DSM-5]; American Psychiatric Association [APA], 2013). They commonly result in malnutrition, dehydration and low body weight (Culbert et al., 2015). Physiologically, EDs can have grave consequences, manifesting as a range of high-risk symptoms, such as low heart rate, blood pressure, blood glucose and body temperature, and electrolyte imbalance (Halmi, 2009; Mitchell & Crow, 2006). Cumulatively, these can result in fatal organ failure (BEAT, 2015; Mitchell & Crow, 2006; National Eating Disorders Association [NEDA], 2012).

It has been argued that EDs are rooted in low self-esteem (Thurstin, 1999) and perfectionist traits (Brown et al., 2012; Thurstin, 1999). EDs have been linked to inflexible, distorted and obsessive thinking (Thurstin, 1999), directly associated to restrictive, compulsive and rule-driven behaviours that govern energy intake and expenditure (e.g. Aspen et al., 2014; Meyer et al., 2011; Taranis & Meyer, 2010). Some researchers have argued that these behaviours provide a sense of personal control (Fox et al., 2011). Cumulatively, EDs have been reported to result in significant psychological distress (BEAT, 2015), dysphoria and worthlessness (Thurstin, 1999) and increased self-harm and suicidality (Halmi, 2009; Koutek et al., 2016; Smith et al., 2018). Overall, EDs have the highest mortality rates of all mental health disorders (BEAT, 2015; Crow et al., 2009).

1.1.1 ED prevalence

Research into the prevalence of ED has attempted to reveal the demand for ED treatment (Smink et al., 2012). This research has tended to focus on anorexia nervosa (AN), leaving the prevalence of other 'feeding and eating disorders' described by DSM-5 (APA, 2013)[1] relatively under-researched (Dahlgren et al., 2017). Irrespective of evidence showing ED prevalence in males (Mitchison & Mond, 2015; Strother et al., 2012; Sweeting et al., 2015), and adults of working and midlife age (Mangweth-Matzek & Hoek, 2017), most

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[1] Other DSM-5 (APA, 2013) EDs include: pica; rumination disorder (RD); avoidant/restrictive food intake disorder (ARFID); bulimia nervosa (BN); binge-eating disorder (BED); and other specified feeding or eating disorder (OSFED); unspecified feeding or eating disorder (UFED). OSFED includes: atypical AN; BN and BED where episodes occur on average less than once a week and/or for less than three months; purging disorder (PD); and night eating syndrome (NES). OSFED and UFED replaced eating disorder not otherwise specified (EDNOS; DSM-IV; APA, 2000) in DSM-5 (APA, 2013).

research has focused on specific populations (Dahlgren et al., 2017; Hoek, 2016). For instance, young, adolescent, white females from Western Europe and North America (Hoek, 2016; Smink et al., 2012). Further, there is evidence to suggest ED prevalence across both developing and developed nations and across cultures (Hoeken et al., 2016; Kolar et al., 2016; Nakai et al., 2014; Perez et al., 2016; Pike et al., 2014; Thomas et al., 2016; Tong et al., 2014).

1.1.2 Inpatient treatment services for EDs

Due to high-risk ED symptoms, treatment can require close monitoring by inpatient psychiatric services (IPS; Halmi, 2009; National Institute for Health and Care Excellence [NICE], 2017a). Traditionally, ED IPS environments have been highly controlled and rigorously observed, and focused on nutritional restoration and medical management (Halmi, 2009). Over time, this focus has evolved to be more holistic, involving a multidisciplinary team (MDT) approach (Halmi, 2009; Holmes et al., 2017) with interventions from psychopharmacological medications (Brown & Keel, 2012; Lutter, 2017; Shapiro et al., 2007) to nutritional advice (Halmi, 2009) and exercise (Danielsen et al., 2018). Further, inpatients have received psychosocial interventions in individual and group formats. This has included cognitive-behavioural therapy (CBT; Fairburn, 2008; Fairburn et al., 2003; NICE, 2017a), arguably the most effective psychological treatment for EDs (Hay et al., 2009; Linardon et al., 2017; Shapiro et al., 2007). In addition, there are psychodynamic, family and interpersonal therapeutic approaches (Agras, 2000; Miniati et al., 2018; NICE, 2017a).

1.1.3 ED IPS cost-effectiveness

It has been argued that ED IPS have vast financial implications for inpatients, their families and wider socio-economic systems due to disruption to education and employment, loss of income from working-age adults, and vast healthcare costs (BEAT, 2015, 2018). In the United Kingdom (UK) in 2015 and 2016, ED IPS cost the National Health Service (NHS) £47,000 per inpatient, 85 per cent of which was spent treating adult inpatients (NICE, 2017b). This is compared with outpatient ED services, which cost the NHS approximately £18,000 per patient in 2015 and 2016 (NICE, 2017b). Indeed, it has been argued that ED IPS are less cost-effective than outpatient services (Gowers et al., 2007; Herpertz-Dahlmann et al., 2014; Williamson et al, 2001). This is concerning, given that the demand for ED IPS treatment has increased and, with this, its financial burdens (BEAT, 2015). Moreover, reviews of attrition

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rates have shown 20.2 to 51 per cent of ED inpatients leave ED IPS treatment prematurely (Fassino et al., 2009; Roux et al., 2016). It has been said that more than half of ED patients move through a recurring six-year cycle of waiting for treatment, treatment, recuperation and relapse, the financial and social implications for patients and their wider systems building over time (BEAT, 2015). Although quantitative research has provided insight into ED prevalence, treatment demand and attrition, it fails to capture why patients get caught in this cycle. As a result, qualitative research has sought to explore inpatients' lived experiences of ED treatment and, specifically, ED IPS.

1.1.4 Qualitative research and reviews

Qualitative research exploring inpatients' experiences of ED IPS has revealed certain themes. For example, the relinquishing and regaining of personal control and responsibility during admittance; relearning normal eating, exercise and social relationships; peer relationships as both beneficial and distressing; and separating from ED diagnoses to regain a sense of personal identity (Colton & Pistrang, 2004; Halse et al., 2005; Offord et al., 2006; Smith et al., 2014; van Ommem et al., 2009; Wu & Harrison, 2019). However, such research has focused on experiences of AN inpatients, limiting the transferability of findings. Moreover, despite the existence of this research, there has been a lack of reviews synthesising qualitative research exploring inpatients' experiences of ED IPS treatment. Instead, qualitative reviews have focused more broadly on experiences of ED recovery and treatment, discussed as follows.

Recently, Stockford et al. (2019) reviewed 14 critically-appraised studies, exploring females' experiences of AN recovery and treatment, across ED IPS and outpatient settings. Participants in the reviewed studies reported poor sense of self, feeling powerless in interpersonal relationships, and AN as an element of their identity. Moreover, they stated the focus of ED treatment remains on weight gain, despite their expressed preference for psychosocial interventions. Participants highlighted the importance of addressing their fragmented senses of self, involving self-acceptance, interrelatedness and the reconstruction of personal identities. However, this review did not incorporate broader ED diagnoses beyond AN, or populations, such as males.

De Vos et al. (2017) conducted a meta synthesis of 18 critically-appraised studies, extracting and quantifying themes around the criteria for ED recovery, across ED IPS and outpatient settings. Most frequently reported themes were decreased ED cognitions and

behaviours, insight into self and personal potential, self-acceptance, having healthy coping mechanisms, positive interpersonal relationships, and autonomy. Although this review included broader ED diagnoses, the meta synthesis technique used (Sandelowski & Barroso, 2003) involved themes being listed and quantified, rather than in-depth exploration of participants' direct quotations, arguably limiting the conclusions drawn (Ludvigsen et al., 2016).

Bezance and Holliday (2013) reviewed 11 critically-appraised studies exploring adolescents' experiences of AN recovery and treatment, across ED IPS and outpatient settings. Participants in the reviewed studies emphasised the importance of maintaining sibling and peer relationships, the latter having the potential to both positively and negatively impact recovery. In addition, participants emphasised the importance of staff receiving ED training to lessen negative staff attitudes towards them and improve therapeutic rapport. Regarding ED IPS specifically, participants reported experiencing ED IPS environments as a threat to their autonomous control, hindering regaining a sense of their personal identity. Further, the importance of individualised care at each stage of the ED IPS process was emphasised. However, although the review included males, it did not incorporate ED diagnoses beyond AN.

1.1.5 Rationale and aim of current review

Cumulatively, there have been a range of reviews of the qualitative literature centring on ED treatment and recovery, revealing some pertinent themes. However, there has been a lack of systematic reviews of qualitative research exploring inpatients' experiences of ED IPS treatment. These experiences are of particular interest, given the increasing demand for ED IPS treatment, as well as its elevated cost and attrition.

Moreover, with the focus of ED IPS treatment having evolved to involve holistic, MDT approaches, there have been no attempts to synthesise qualitative research on inpatients' experiences of specific, named ED IPS interventions, across MDT disciplines and intervention formats (individual and group). Such a review could lead to clinical recommendations applicable to all ED IPS interventions, and that could contribute to improving ED IPS efficacy. A review focusing the experiences of adults of working age would be particularly relevant, given the greater impact of their ED IPS care on wider economies.

Therefore, this review aims to systematically review the qualitative literature exploring the experiences of adults of working age, regarding specific, named ED IPS interventions, delivered across the MDT (i.e. psychiatry, psychology, nursing, occupational therapy and physiotherapy) in individual and group formats. This review will aim to answer the question: 'What are ED inpatients' experiences of specific, named ED IPS interventions?' Further relevant research, regardless of the participants' gender, ethnicity or cultural and geographic location, with symptoms of any ED diagnoses in DSM-IV-TR (APA, 2000) or DSM-5 (APA, 2013) will be incorporated in this review.

1.2 Method

1.2.1 Literature search

1.2.1.1 Search process

A systematic search of the relevant literature exploring individuals' experiences of specific, named ED IPS interventions was carried out between November and December 2019. Relevant databases covering the literature in nursing and psychology disciplines were searched to identify relevant studies, including: PsycINFO, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science and Scopus. ProQuest Dissertations and Theses was used to search for relevant, unpublished grey literature, while Google Scholar was used to search for relevant websites. Reference lists of extracted studies were scrutinised by hand to identify any additional relevant studies.

1.2.1.2 Key search terms and strategy

Table 1.1 shows an overview of all the key search terms (KSTs) and search locations.

Table 1.1

Key search terms used for literature search

Main concept	Variations	Location
eating disorder*	anorex* bulimi* "binge eating disorder*" binge-eating disorder* pica "avoidant restrictive food intake disorder*" ARFID "rumination disorder*" "other specified feeding or eating disorder*" OSFED "purging disorder*" "night eating syndrome*" NES "eating disorder not otherwise specified" EDNOS "unspecified feeding or eating disorder*" UFED	Title Abstract
inpatient*	in-patient "psychiatric hospitali*" hospitali* institutionali*	Title Abstract
treatment*	intervention* therap* program* strateg* technique* approach* group* individual* "one to one*" one-to-one*	Title Abstract
experience*	attitude* view views perception* perspective* opinion*	Title Abstract

KSTs comprised main concepts and their synonyms, decided in collaboration with the subject librarian. Where necessary, an asterisk (*) was used to truncate KSTs and search for all possible word endings. Speech marks (" ") were used to group words together that were not linked using hyphens, searching for them as a single phrase. KSTs were configured using the BOOLEAN search strategy: 'OR' was used to link main concepts and variations; 'AND' was

used to combine main concepts. Adjacency terms (e.g. 'ADJ3', or its equivalent) were used to find the KSTs 'individual*'/"one to one*"/one-to-one or 'group*' within two words (or fewer) of treatment KSTs.

1.2.1.3 Initial screening

The titles and abstracts of the studies yielded by the search were initially screened and kept if (a) they were written in English, (b) they described ED-diagnosed individuals' experiences of specific, named ED IPS interventions and (c) access to the full text was available. The full texts of remaining studies were scrutinised against specific inclusion and exclusion criteria.

1.2.2 Inclusion and exclusion criteria

Table 1.2 shows an overview of the specific inclusion and exclusion criteria applied in this review.

Table 1.2

Inclusion and exclusion criteria

Criterion	Include	Exclude
Participants	Previously received or currently receiving a specific, named inpatient intervention for treatment of EDs.	Previously received or currently receiving a specific, named inpatient intervention for treatment of symptoms of mental health symptomologies other than EDs. Previously received or currently receiving treatment, for ED or otherwise, but as an outpatient.
	18 years old and over at time of inpatient treatment for ED. All ages, where data from individuals 18 years old and over could be extracted.	17 years old and under only at time of inpatient treatment for ED.
Article type	Qualitative methods only Mixed methods, where qualitative data could be extracted.	Quantitative methods only
Focus	Patients' experiences	Other people's experiences (e.g. family, carers, professionals).
	Experiences of specific, named inpatient ED interventions (psychological and non-psychological, individual and group formats).	Experiences of involuntary admittance to inpatient setting. Experiences of inpatient environment, regime, routine, protocol. Experiences of therapists or therapeutic alliance.
Language	English	Any other language
Publication date	1995 to present	Before 1995

Studies were included if participants (a) had previously received or were currently receiving a specific, named ED IPS intervention and (b) were 18 years old or over at the time of admission. Studies with broader age ranges were included where the data for participants 18 years old or above could be extracted. Studies that were either (a) purely qualitative or (b) mixed methods were included. No restrictions were placed on gender, sample size, recruitment method, location or methods of data collection, or data analysis methods. Studies were included if they focused on patients' experiences of a specific, named ED IPS intervention, as described in Table 1.2.

Due to changes to ED interventions in the early 1990s[2] (Richards et al., 2000), studies were only included if they were published during or after 1995. Studies were excluded if participants had previously received or were currently receiving a specific, named IPS intervention for mental health disorders other than EDs, or if they were receiving outpatient ED treatment. Defining adults as those 18 years old or over, studies were also removed if participants were 17 years old or under at the time of ED IPS admission. Qualitative or mixed methods studies reporting on the experiences of individuals other than patients (e.g. carers, professionals) were excluded. Those reporting on the experiences of ED IPS care environments, more broadly, were also excluded.

1.2.3 Classification of studies

The selection process for studies included in this review was recorded on a 'preferred reporting items for systematic reviews and meta-analyses' (PRISMA) flow diagram (Figure 1.1; Moher et al., 2009).

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[2] Treatment interventions for EDs evolved rapidly during the 1980s and 1990s (Richards et al., 2000). This saw the development of various psychopharmacological, psychodynamic, behavioural, cognitive behavioural, dialectic behavioural, interpersonal, family, and supportive-expressive approaches, many of them in the early 1990s (Kennedy & Garfinkel, 1992; Telch et al., 2000, 2001; Wilson & Fairburn, 1993; Yager, 1988; Zerbe, 1992). This resulted in a peak in outcome research, measuring the efficacy of such approaches, also in the early to mid 1990s (e.g. Fairburn & Hay, 1992; Johnson et al., 1996; Kennedy & Garfinkel, 1992).

Figure 1.1

PRISMA flow diagram showing the selection process for studies included in this review
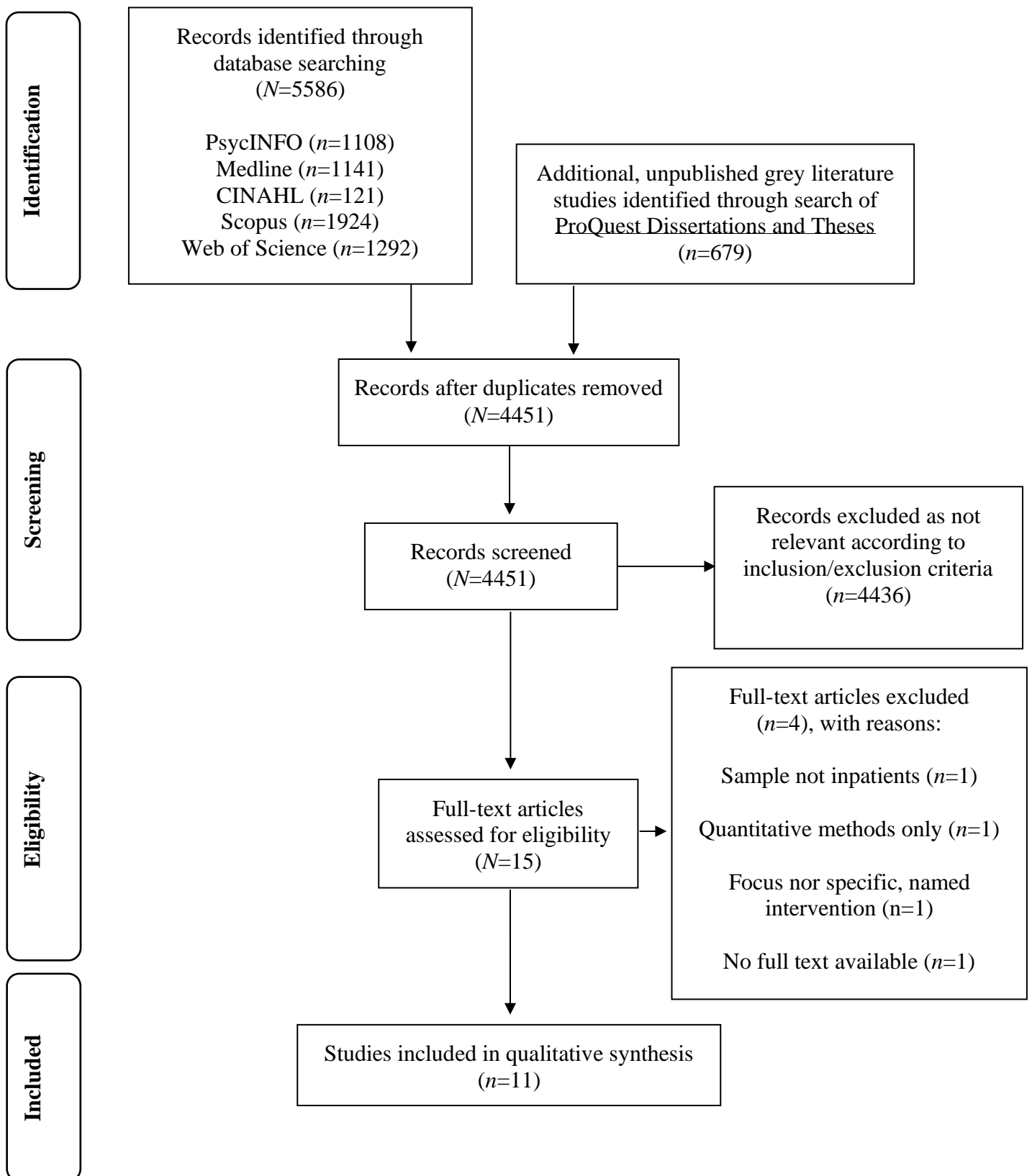
Initially, a total of 5586 studies were identified through database searches. A further 679 unpublished, grey literature studies were obtained through ProQuest Dissertations and Theses, totalling 6265 studies. Of these, 1814 were duplicates, resulting in 4451 to be screened according to the inclusion and exclusion criteria. After manual reviewing of titles and abstracts, a further 4435 were excluded as not being directly relevant according to the inclusion and exclusion criteria. The full text of the remaining eligible 15 studies were studied and a further four excluded due to (a) the sample not being inpatients, (b) the methods being quantitative only, (c) the focus not being on a specific, named intervention and (d) no full text was available. A total of 11 relevant studies were identified as meeting the inclusion criteria and retained for quality assessment.

1.2.4 Quality assessment

1.2.4.1 Quality assessment tool

It is important to have a structured method to appraise the quality of qualitative research (Oakley, 2000). This review applied the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018) to each of the identified studies. This examines the different underpinnings and assumptions of qualitative research (Tong et al., 2012). The checklist consists of 10 quality criteria, pertaining to findings, their validity and wider value.

The CASP checklist was chosen because it is commonly implemented to appraise reports of qualitative research (Majid & Vanstone, 2018; Pope et al., 2007). It has been frequently used to assess the quality of literature in reviews focusing on individuals' experiences of treatment interventions (Staniszewska et al., 2019) and the experiences of individuals diagnosed with EDs (e.g. Johns et al., 2019; Stockford et al., 2019).

1.2.4.2 Quality calculation

All 11 studies were scored against the CASP (2018) using a scoring methodology described by Butler et al. (2016) whereby studies being appraised can yield a score between zero and 10, falling into one of four quality categories: 'low and remove' (0 to 5.5), 'low and retain' (6 to 7), 'moderate' (7.5 to 8.5), and 'high' (9 to 10). The 'low and retain' quality category creates a buffer between studies falling in the 'low and remove' category, scoring zero to 5.5, and those falling in the 'moderate' quality category. Butler et al. (2016) and other researchers maintain the exclusion of studies scoring below a certain cut-off is an important part of conducting systematic literature reviews, ensuring validity of results (Campbell et al.,

2003; Estabrooks et al., 1994; Yin et al., 1976). None of the studies appraised for this review scored zero to 5.5, and so all were retained for inclusion in the review. See Appendix B for the score breakdowns.

1.2.4.3 Quality assessment reliability checks

To improve the reliability of quality assessment, an additional researcher scored all of the studies independently, using the same quality assessment criterion (see Appendix C). Subsequently, an inter-rater reliability analysis was completed using the Kappa co-efficient, which yielded a Kappa score for each article, ranging from $k=.630$ to $k=1$, indicating moderate to very strong agreement reliability (Altman, 1999).

1.2.5 Characteristics of studies

Table 1.3 summarises the key characteristics of the 11 studies.

Table 1.3

Characteristics of studies reviewed (in alphabetical order)

Author/s, date and location	Aim/s or questions Intervention delivery type	Research design	Sample population: age, number, gender, diagnosis, setting (where provided)	Data collection method	Analysis and approach (where specified)	Key findings: themes and subthemes, or categories and subcategories (where provided)	Quality rating and Kappa rating

Albertsen, Natvik and Raheim (2019)
 	
Norway
	Explore individuals' experiences of Basic Body Awareness Therapy (BBAT).
	
	Individual intervention.
		Qualitative	Age: 20s and 40s (not explicit); *N*=2 Gender: females *n*=2, males *n*=0 Diagnosis: BED Setting: specialist inpatient ED unit	Semi-structured interviews, supported by video-recorded observations of treatment sessions and participants' written diaries.	Phenomenological analysis	Theme and subthemes:
						1. "On the way from the body as problem to the body as possibility":
						  a. "Emotions: from avoiding difficult emotions toward new emotional experiences"
						  b. "Movement: from guilt and discomfort toward joy and well-being"
						  c. "Pain: from being controlled by pain toward living with pain through self-care"
						  d. "Calmness: toward finding calmness in the body even in
							9/10
							
							High quality
							
							k=.74

						e. "Self-experience: from self-hate toward finding strength from within"	

Albertsen et al. (2019, p. 31)

| Hedlund and Landgren (2017)

Sweden | Explore meaning of individuals' lived experiences of receiving ear acupuncture treatment

Individual intervention | Qualitative | Age: 22–55 years
N=9
Gender: females *n*=9; males *n*=0
Diagnosis: AN
Setting: specialist inpatient ED unit | Semi-structured interviews. | Phenomenological analysis | Themes and subthemes:
1. "Creating a pause, a framework for rest and reflection":
  a. "Searching for a handle to hold onto"
    - "Holding onto the handle"
    - "Regaining control"
  b. "Acupuncture as a pause button":
    - "Relaxing and resting makes a difference"
    - "Acupuncture having a palpable effect" | 8/10

Moderate quality

k=1 |

						- "Thinking clearer" (Hedlund & Landgren, 2017, p. 3).	
Holmes, Drake, Odgers and Wilson (2017) UK	Discuss and evaluate 10-week group intervention, based on feminist approach to EDs Group intervention	Qualitative	Age: 19–51 years *N*=7; Gender: females *n*=7; males *n*=0 Diagnosis: AN Setting: inpatient unit	Semi-structured interviews	Thematic discourse analysis	Themes: 1. "The availability and troubling of media blaming" (Holmes et al., p. 7), 2. "Feminist approaches to eating disorders as offering a form of 'protective' barrier" (p. 8) 3. "Tensions between feminist and individualised understandings of eating disorders" (p. 9) 4. "Ambivalent reactions to feminism" (p. 10) No subthemes reported.	9.5/10 High quality *k*=1
Larsson, Lloyd, Westwood and Tchanturia (2018)	Explore experiences of perfectionism group intervention	Qualitative	Age: 19–45 years *N*=14 Gender: females *n*=14, males *n*=0 Diagnosis: AN	Focus groups (using semi-structured interview schedule)	Thematic discourse analysis	Themes and subthemes: 1. "Perceived benefits": a. "Benefits of group setting": - "Sharing experiences and	7.5/10 Moderate quality *k*=.643

UK	Group intervention	Setting: specialist inpatient ED unit		learning from others"
				- "Awareness of similarities and differences in experiences of perfectionism"
				- "Extension beyond sessions"
				- "Challenges of the group setting"
				b. "Awareness and self-reflection":
				- "Awareness of perfectionism"
				- "Recognising the negative impact of perfectionism"
				- "Excellence versus perfectionism"
				- Bigger picture "thinking"
				2. "Nature of group":
				a. "Practical/interactive nature of the group"
				b. "Application outside of the group: homework"
				3. "Suggested improvements":

						a. "Increased number of sessions" b. "Further support in application and setting of goals" c. "Focus on additional areas" (Larsson et al., 2018, p. 1525)	
Morgan, Lazarova, Schelhase and Saeidi (2014) UK	Determine effectiveness of body image therapy Group intervention	Mixed methods	Age: 18–42 years *N*=55 Gender: females *n*=53, males *n*=2 Diagnosis: AN Setting: specialist inpatient ED unit	Questionnaires	Interpretative phenomenological analysis	Themes: 1. "Behavioural change" 2. "Changed core beliefs" 3. "Anxiety provocation" 4. "Mindfulness" 5. "Group heterogeneity" (Morgan et al., 2014, p. 69) No subthemes reported.	6.5/10 Low quality *k*=.54
Owen and Fullerton (1995) USA	Discuss the development and implementation of an inpatient ED discussion group Group intervention	Qualitative	Age: 18–29 years *n*=23; 30–39 years *n*=2; 40–49 years *n*=3; >49 years *n*=1; *N*=29 Gender: females *n*=27, males *n*=2	Questionnaires	Unknown	No themes or subthemes reported. Results grouped into: • "What patient liked most about group" • "What patients liked least about group"	6/10 Low quality *k*=.8

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			Diagnoses: n=9 AN, n=13 BN, n=7 AN and BN Setting: general psychiatric inpatient unit			• "Suggestions on how to improve the group for future patients". (Owen & Fullerton, 1995, p. 38) Conclusion: ED discussion group had a positive impact and improved an inpatient ED programme	
Padfield, Tominey and Matthews (2017) UK	Provide description and evaluation of therapeutic writing group Group intervention	Qualitative	Age: 18–30 years n=9, >30 years n=4; N=13 Gender: females n=12, males n=1 Diagnoses: 81% AN, 3% BN, 10 % EDNOS, 6% personality disorder (no explicit N) Setting: specialist inpatient ED unit	Questionnaires	Thematic discourse analysis	Themes: 1. "Group dynamics" (Padfield et al., 2017, p. 326) 2. "Interpersonal learning" (p. 327) 3. "Emotional expression and exploration" (p. 327) 4. "Logistics and facilitation" (p. 328) No subthemes reported.	7/10 Low quality k=.63
Padrão and Coimbra (2011)	"collect relevant material on … the	Qualitative	Age: 15–56 years (not more specific, but	Semi-structured interviews	Grounded theory	No themes or subthemes reported.	6.5/10

Portugal	movement characteristics/ preferences revealed by patients" (Padrão & Coimbra, 2011, p. 139) Group intervention		able to separate out feedback of under and over 18–year-olds); *N*=7 Gender: females *n*=7, males *n*=0 Diagnosis: AN Setting: inpatient setting			Conclusion: "results seem to support some theoretical assumptions and allow the interpretation of empirical findings" (Padrão & Coimbra, 2011, p. 139)	Low quality *k*=.84
Sparrow and Tchanturia (2016) UK	Evaluate individuals' feedback on brief psychotherapy group interventions Group intervention	Qualitative	Age: over 18 years; *N* unknown Gender: females Diagnosis: AN Setting: specialist inpatient ED unit	Questionnaires	Thematic discourse analysis	Categories: 1. Social aspects of group 2. Practical aspects of group. No sub-categories reported.	7/10 Moderate quality *k*=.81

Tchanturia, Doris and Fleming (2014)
 	
UK
	Evaluate brief Cognitive Remediation and Emotion Skills Training (CREST) group
	
	Group intervention
		Mixed methods	Age: *M*=27.9 (*SD* unreported) *N*=36 Gender: females *n*=36; males *n*=0. Diagnosis: AN Setting: specialist	Questionnaires	Unknown	Categories and subcategories:
						1. What participants liked about the group:
						  a. "Sharing and discussion"
						  b. "Talking and learning about emotions"
						  c. "Interactive",
						  d. "Practical tasks",
							6.5/10
							
							Low quality
							
							k=.69

			inpatient ED unit				e. "Safe space", f. "Staff". 2. Suggested improvements: a. "More practical tools for dealing with emotions" b. "Variety of content" c. "Greater attendance and participation" d. "More sessions". (Tchanturia et al., 2014, p. 203)	
Zuchova, Erler and Papezova (2013) Czech Republic	Explore viability and suitability of Cognitive Remediation Therapy group and pose changes for future use	Qualitative	Age: 18–45 years N=34 Gender: females n=33, males n=1 Diagnosis: AN Setting: specialist inpatient ED unit	Questionnaires	Unknown	No themes or subthemes reported. Conclusion: feedback showed CRT group was well received by participants.	6/10 Low quality k=1

All of the studies aimed to explore the participants' experiences of ED IPS interventions. Further, all of the studies had psychological and/or social focuses. Three were carried out by Tchanturia and her colleagues (Larsson et al., 2018; Sparrow & Tchanturia, 2016; Tchanturia et al., 2014), and the remaining ones by a range of other authors. All except one study (Owen & Fullerton, 1995) were completed in the last 10 years.

Sample sizes ranged from two (Albertsen et al., 2019) to 55 (Morgan et al., 2014), with one study failing to explicitly state the total number of participants (Sparrow & Tchanturia, 2016). All of the studies used sample populations from western cultures (Makino et al., 2004). Of these, one used sample populations in the USA (Owen & Fullerton, 1995) and the remainder in Europe, including six from the UK (Holmes et al., 2017; Larsson et al., 2018; Morgan et al., 2014; Padfield et al., 2017; Sparrow & Tchanturia, 2016; Tchanturia et al., 2014). Two studies used mixed methods (Morgan et al., 2014; Tchanturia et al., 2014) and the remainder were qualitative, using a variety of data collection methods. These included semi-structured interviews (Albertsen et al., 2019; Hedlund & Landgren, 2017; Holmes et al., 2017; Padrão & Coimbra, 2011), questionnaires (Morgan et al., 2014; Owen & Fullerton, 1995; Padfield et al., 2017; Sparrow & Tchanturia, 2016; Tchanturia et al., 2014; Zuchova et al., 2013) and a focus group (Larsson et al., 2018).

All of the studies sampled adult participants, the majority of whom were females. Three studies included males (Owen & Fullerton, 1995; Morgan, et al., 2014; Zuchova et al., 2013). A total of six males were included across all studies, out of a total number of participants exceeding 172 (the total number is unknown due to Sparrow & Tchanturia [2016] failing to report the number of participants included). One study failed to report the participants' genders (Padfield et al., 2017). Across the studies, 73 per cent sampled participants with AN only, the remainder including diagnoses of BN, BED and EDNOS only. Four studies included participants with diagnoses of BN, BED, EDNOS, OSFED, UFED and personality disorders (Albertsen et al., 2019; Owen & Fullerton, 1995; Padfield et al., 2013). Two studies explored the experiences of individual interventions (Albertsen et al., 2019; Hedlund & Landgren, 2017) and the rest of group interventions.

1.2.6 Analysis and synthesis methodology

Thematic synthesis (TS) was selected for analysing and synthesising qualitative data, applying the stages outlined by Thomas and Harden (2008; Table 1.4) to each of the included studies.

Table 1.4

Stages of thematic synthesis (based on Thomas & Harden, 2008)

Stage number and name	Details
1. Text coding	Review questions are put aside (to avoid the imposition of an a priori framework). Start data-driven searching of findings, contained in study abstract and results/findings sections. Line-by-line, the content and meaning of findings are studied and coded in margins. All codes are recorded in a code book.
2. Descriptive theme development	Review questions continue to be put aside. Codes across studies are collated in the code book, studied and analysed for their meanings. Codes are organised into descriptive themes, which are analysed for their characteristics.
3. Analytical theme development	Descriptive themes are studied and compared with one another, to ascertain how they are similar and dissimilar. With the review questions in mind, descriptive themes are then used to make inferences (e.g. novel concepts and hypotheses) that answer the original questions of the review questions. These are higher-order constructs, known as analytical themes, which extend beyond the original findings of the included studies.

TS was selected because it is congruent with the idealist and interpretive stance of this review: discouraging assumptions of objectivity and emphasising subjectivity, TS moves towards the development of new theory (Bearman & Dawson, 2013; Butler et al., 2016; Thomas & Harden, 2008). Also, TS addresses the limitations outlined by Dixon-Woods et al. (2006) that syntheses based on themes do not (a) transparently outline their steps and (b) move from data-driven descriptive themes to theory-driven analytical themes (Thomas & Harden, 2008). Lastly, the research questions commonly answered by TS are often about intervention suitability and efficacy (Ring et al., 2011).

1.3 Results

1.3.1 Overview of quality assessment results

Eleven studies proceeded to quality assessment; the resulting quality scores and ratings for each are shown in Table 1.4. No studies scored below six, and so all were retained for inclusion in the review. Two studies were rated as high quality (Albertsen et al., 2019; Holmes et al., 2017); three were rated as moderate quality (Hedlund & Landgren, 2017; Larsson et al., 2018; Sparrow & Tchanturia, 2016); and six were rated as low quality

(Morgan et al., 2014; Owen & Fullerton, 1995; Padfield et al., 2017; Padrão & Coimbra, 2011; Tchanturia et al., 2014; Zuchova et al., 2013). See Appendix B for the score breakdowns.

1.3.2 Overarching theme, analytical themes and analytical subthemes

Several descriptive themes (DTs) emerged through data-driven coding, which were studied and compared for similarities and differences, before being arranged into a hierarchical tree diagram (see Appendix D). DTs were used to make inferences, in the form of an overarching theme, analytical themes (ATs) and analytical subthemes (ASTs), to address the research question. Figure 1.2 depicts these themes in a hierarchical tree diagram.

Figure 1.2

Hierarchical tree diagram of overarching analytical theme, analytical themes and analytical subthemes
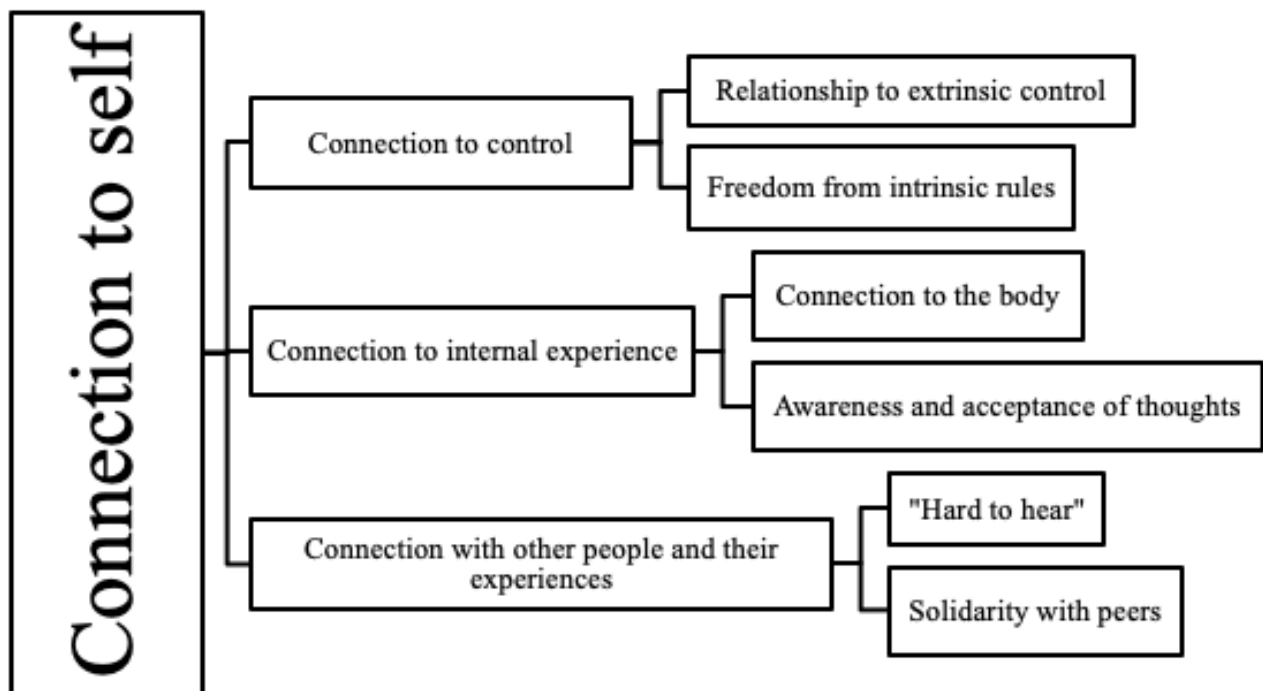
1.3.2.1 Overarching theme: 'Connection to self'

Participants in the reviewed studies experienced ED IPS interventions as facilitating increasing 'connection to self' (overarching theme), constituting regaining a healthy autonomy, awareness and acceptance of their cognitions and bodies, and connection with other people (peers and their wider socio-cultural contexts). This was achieved through the

following ATs: 'connection to control', 'connection to internal experience' and 'connection with other people and their experiences'. Each AT was subdivided into further ASTs, as follows.

1.3.2.1.1 'Connection to control'. Participants in six studies experienced growing 'connection to self' through changes in their 'connection to control', through the ASTs 'relationship to extrinsic control' and 'freedom from intrinsic rules' (Hedlund & Landgren, 2017; Owen & Fullerton, 1995; Padfield et al., 2017; Padrão & Coimbra, 2011; Tchanturia et al., 2014; Zuchova et al., 2013).

1.3.2.1.1.1 'Relationship to extrinsic control'. Participants in three studies of low quality (Owen & Fullerton, 1995; Padfield et al., 2017; Padrão & Coimbra, 2011) and one of moderate quality (Hedlund & Landgren, 2017) spoke about their relationships to extrinsic control, meaning externally-imposed rules and structure of ED IPS interventions. Participants in one study (Owen & Fullerton, 1995), exploring experiences of a therapeutic writing group, preferred it when interventions exerted control over group topics that were otherwise unstructured, unfocused and uncontained. Others found that broad therapeutic writing group topics made it difficult to know what to write about and begin writing (Padfield et al., 2017).

Conversely, participants in three studies (Hedlund & Landgren, 2017; Padfield et al., 2017; Padrão & Coimbra, 2011) spoke positively about interventions that allowed them to make autonomous choices surrounding their interventions:

> *"And it being optional. Yes, it's important to be able to decide something for yourself and yes, to have choice ..."* (Hedlund & Landgren, 2017, p. 4)

This participant in an individual acupuncture intervention (Hedlund & Landgren, 2017), spoke about the importance of being able to autonomously make decisions around intervention participation, a welcomed freedom from the otherwise unrelenting extrinsic control of the ED IPS environment.

Other participants echoed this, speaking about the importance of being permitted choices during interventions: for instance, making decisions about how much of their therapeutic writing to read out to other group participants (Padfield et al., 2017); and whether to observe or actively participate during interventions (Padrão & Coimbra, 2011). In addition,

participants experienced being able to stipulate how many needles were administered during acupuncture by assuming responsibility (Hedlund & Landgren, 2017).

1.3.2.1.1.2 'Freedom from intrinsic rules'. Participants in two studies of low quality (Padfield et al., 2017; Zuchova et al., 2013) and one of moderate quality (Hedlund & Landgren, 2017) reported that interventions permitted them 'freedom from intrinsic rules', meaning the self-imposed rules participants exerted over themselves:

> *"the writing group was a place to be free in. Not free from emotions or fear, but free of rules. Eating disorders are full of rules; everything can become a rule, so for me it was somewhere I could breathe, let go and just 'be' for a while."*
> (Padfield et al., 2017, p. 330)

Here, this participant spoke about interventions permitting them to let go of their self-imposed, compulsive and restrictive rules, and to just exist in the moment, but without shutting off difficult emotions, such as fear.

Participants in Hedlund and Landgren's study (2017) of moderate quality highlighted that 'freedom from intrinsic rules' was enabled by "resting within [a] framework" (p. 4), extrinsically imposed by the intervention, which stipulated they remain still:

> *"For me it's been good to have a framework, and to rest within that framework ... knowing that now, while sitting with these needles, I can't get up and walk around."* (Hedlund & Landgren, 2017, p. 4)

For this participant – linking back to 'relationship to extrinsic control' – resting in extrinsic control allowed them 'freedom from intrinsic rules' around compulsively exercising after meals, which led to physical relaxation. Therefore, the findings from both Padfield et al. (2017) and Hedlund and Landgren (2017) demonstrate how 'freedom from intrinsic control' altered participants' 'connection with internal experience' such as emotions and the body, respectively, as discussed next.

1.3.2.1.2 'Connection with internal experience'. Participants in nine of the eleven studies spoke about 'connection with internal experience' as contributing to their 'connection to self' (Albertsen et al., 2019; Hedlund & Landgren, 2017; Holmes et al., 2017; Larsson

et al., 2018; Morgan et al., 2014; Padfield et al., 2017; Padrão & Coimbra 2011; Tchanturia et al., 2014; Zuchova et al., 2013). Of these nine studies, two explored individual interventions (Albertsen et al., 2019; Hedlund & Landgren, 2017) and the other seven explored group interventions, demonstrating that 'connection with internal experience' was effectively incorporated into both intervention formats. 'Connection with internal experience' was spoken about in terms of the ASTs (a) 'connection to the body' and (b) 'awareness and acceptance of thoughts', as follows.

1.3.2.1.2.1 'Connection to the body'. Participants in two studies of low quality (Morgan et al., 2014; Padrão & Coimbra, 2011), one of moderate quality (Hedlund & Landgren, 2017) and one of high quality (Albertsen et al., 2019) spoke about 'connection to internal experience' in terms of interventions increasing their awareness of, connection to and ownership of their bodies, demonstrating 'connection to the body'. These studies explored participants' experiences of body image therapy groups (Morgan et al., 2014) and a dance/movement psychotherapy group (Padrão & Coimbra, 2011), as well as individual acupuncture (Hedlund & Landgren, 2017) and basic body awareness (Albertsen et al., 2019) interventions.

Participants in two of these studies (Albertsen et al., 2019; Hedlund & Landgren, 2017) spoke about interventions enabling physical relaxation and rest that led to increased awareness of physiological sensations:

> *"to find my center, to find my breathing. I was actually so incredibly proud … I managed to do this on my own."* (Albertsen et al., 2019, p. 8)

This participant was commenting on achieving awareness of breathing, which was associated with pride. This positive change in emotions was echoed by other participants, who reported increased "harmony" (Albertsen et al., 2019, p. 7) and a decreased sense of burden of having an ED through having a "small weight lifted from their shoulders" (Hedlund & Landgren, 2017, p. 3). In the same two studies, 'connection to the body' was linked to decreased physiological "discomfort", "the disgusting sensation of fullness" (Hedlund & Landgren, 2017, p. 4) and physical pain (Albertsen et al., 2019); these are all known ED symptoms. In addition, there was an increased ability to think "more logically" (Hedlund & Landgren, 2017, p. 5), linking 'connection to the body' to 'awareness and acceptance of thoughts', as described below.

Lastly, participants in two of the studies (Albertsen et al., 2019; Padrão & Coimbra, 2011) reported how this 'connection to the body' changed their relationships to their bodies:

"I do not want to get rid of my body now. It's mine." (Albertsen et al., 2019, p. 9)

For this participant, this meant feeling more integrated with, and compassionate towards, their body, taking ownership of it.

1.3.2.1.2.2 'Awareness and acceptance of thoughts'. Participants in two studies of low quality (Morgan et al., 2014; Tchanturia et al., 2014) and one of moderate quality (Larsson et al., 2018), evaluating experiences of group interventions, spoke about growing 'awareness and acceptance of thoughts'. For instance, awareness of personal thinking styles (e.g. perfectionism; Larsson et al., 2018), and negative assumptions (Morgan et al., 2014):

"Increasing awareness of my thinking styles by looking at negative patterns and their impact on my perception of a situation." (Tchanturia et al., 2014, p. 203)

This participant talked about the positive impact of this growing awareness on their broader perspectives. More broadly, participants spoke about this awareness altering their cognitions, views and core beliefs. For instance, participants in an individual intervention spoke about the impact in terms of a resultant decrease in "sick thoughts" (anorectic thoughts around food, eating, exercise and weight; Hedlund & Landgren, 2017, p. 5). While participation in a group intervention was associated with increased clarity of mind and ability to reflect which, again, resulted in gaining broader perspectives:

"Now I can kind of take a step back and say it's a tiny detail and it doesn't really affect my entire life … you can just be content with the overall picture."
(Larsson et al., 2018, p. 1526)

Other participants spoke about increasing 'awareness and acceptance of thoughts' as changing their views and beliefs. For instance, participants in a moderate quality study, exploring experiences of an individual acupuncture intervention, reported:

"That might have made me allow myself to gain weight, something I didn't do before.
It feels like somehow I accept things and can handle them."
(Hedlund & Landgren, 2017, p. 5)

Here, this participant spoke about a new view of weight gain, coming to accept it as part of recovery. Participants of an individual body awareness intervention (Albertsen et al., 2019) and a dance/movement group (Padrão & Coimbra, 2011) reported altered beliefs about weight and body shape. Participants of another study, exploring experiences of an emotion identification and regulation skills group, reported more positive attitudes towards themselves (Zuchova et al., 2013). Participants in Morgan et al.'s study (2014), who took part in a body image group, reported altering, more positive core beliefs about themselves. Participants in two further studies – exploring experiences of a group focused on perfectionist thoughts and behaviours (Larsson et al., 2018) and a group rooted in feminist ED approaches (Holmes et al., 2017) – reported altered beliefs about the causes of EDs, incorporating societal influences, which reduced self-blame.

Participants in two studies, rated as moderate quality (Hedlund & Landgren, 2017) and high quality (Albertsen et al., 2019), experienced individual interventions that enabled 'awareness and acceptance of thoughts' as having enduring positive impacts on emotional wellbeing. These studies explored experiences of an individual acupuncture intervention (Hedlund & Landgren, 2017) and an individual body awareness intervention (Albertsen et al., 2019). These participants reported feeling calmer, more centred, comfortable, motivated, empowered and "in control" (Albertsen et al., 2019, p. 7), with less "anxiety before meals" (Hedlund & Landgren, 2017, p. 4) and "terror for gaining weight" (Hedlund & Landgren, 2017, p. 5).

1.3.2.1.3 'Connection with other people and their experiences'. Participants of group interventions spoke about 'connection to self' being impacted by 'connection with other people and their experiences', meaning peers and individuals in wider society. Participants in seven studies spoke about 'connection with others' (Holmes et al., 2017; Larsson et al., 2018; Morgan et al., 2014; Owen & Fullerton, 1995; Padfield et al., 2017; Sparrow & Tchanturia, 2016; Tchanturia et al., 2014), in terms of: (a) material that was "hard to hear", (b) 'solidarity with peers' and (c) 'connecting with others' experiences', as follows.

1.3.2.1.3.1 "Hard to hear". Participants in two studies rated as low quality (Owen & Fullerton, 1995; Padfield et al., 2017) and one of moderate quality (Larsson et al., 2018) – exploring experiences of ED discussion, therapeutic writing and perfectionism groups, respectively – reported sometimes finding it difficult to hear what peers had to say during groups:

> *"Like things you hadn't considered or, like, didn't want to consider, having to listen to them and sometimes I don't think it's very helpful."* (Larsson et al., 2018, p. 1526)

Such participants reported hearing what peers had to say sometimes brought unwanted material into their conscious awareness that was "hard to hear" (Padfield et al., 2017, p. 327), which they had not previously thought of, or had avoided thinking about. Others found "some of the comments" (Owen & Fullerton, 1995, p. 38) of their peers unhelpful (Larsson et al., 2018; Owen & Fullerton, 1995). Participants in Morgan et al.'s study (2014) linked this to group heterogeneity: with some group participants more motivated towards change and, further into recovery, for other participants, 'connection with others and their experiences' meant hearing difficult material that they had previously not considered or avoided, and which did not fit with their readiness to change and/or their recovery journey.

1.3.2.1.3.2 'Solidarity with peers'. Participants in three studies of low quality (Owen & Fullerton, 1995; Padfield et al., 2017; Tchanturia et al., 2014), two of moderate quality (Larsson et al., 2018; Sparrow & Tchanturia, 2016) and one of high quality (Holmes et al., 2017) – exploring experiences of ED discussion, therapeutic writing, emotional regulation and perfectionist thoughts and behaviours groups, respectively – spoke about 'solidarity with peers'. For some, this meant taking part in interactive tasks:

> *"The whole interactive, practical side of doing things was really helpful … we actually played games … it meant you were able to kind of completely immerse yourself in the group."* (Larsson et al., 2018, p. 1527)

This participant spoke about interactive tasks as an "engaging and enjoyable" (p. 1527) way to absorb themselves in group topics and peer interactions. Other participants, in their recommended group improvements, suggested more role plays (Sparrow & Tchanturia,

2016), bigger groups and increased participation from others (Tchanturia et al., 2014) as ways to experience 'solidarity with peers'.

In all six studies, the participants spoke about the value in having shared experiences with peers:

> *"Other people kind of reassured us and said we have it too, you are not alone in this ... it generated a kind of feeling of community in the group as well."*
> (Larsson et al., 2018, p. 1525)

These participants commented that shared experiences were associated with decreased feelings of aloneness. Other participants echoed this, reporting feeling "closer to their peers" (Padfield et al., 2016, p. 327) as a result of shared experiences.

Participants in Holmes et al.'s high-quality study (2017), exploring experiences of a group rooted in feminist approaches to EDs, linked shared experiences to changes in their views around the causes of EDs:

> *"if you're with a load of different people ... with lots of different upbringings, if you all think the same thing about certain things, there must be a reason why that is and then you can discuss whether that's ... cultural."* (Holmes et al., 2017, p. 8)

This participant spoke about shared experiences on topics around gender constructions and socio-cultural factors, which led to viewing EDs in terms of their systemic causes, which led to decreased self-blame. That said, not all participants in Holmes et al. (2017) experienced changed views positively:

> *"But then it's like ... if society's norms are disordered ... then ... I don't know, how am I meant to change kind of thing?"* (Holmes et al., 2017, p. 9)

This participant explained how discussing EDs in terms of being caused by society may have lessened self-blame but it also made them feel powerless over their recovery.

Participants in four studies, ranging from low quality (Larsson et al., 2018; Owen & Fullerton, 1995; Padfield et al., 2017; Tchanturia et al., 2014) to moderate quality (Sparrow & Tchanturia, 2016), reported that 'solidarity with peers' fostered a group culture that was "useful and valuable" (Padfield et al., 2017, p. 326). Others concurred, reporting that

groups were a "safe environment for open discussion" (Sparrow & Tchanturia, 2016, p. 436), linking back to 'freedom to open up and share', with some participants finding listening to others resulted in them learning new things about themselves (Owen & Fullerton, 1995). Some commented that the resultant solidarity pervaded the wider ED IPS environment:

> *"We've been able to challenge each other outside of the group and make it into a bit of a joke sometimes."* (Larsson et al., 2018, p. 1526)

However, participants in two of these studies spoke about group cultures being "sometimes kind of toxic" (Larsson et al., 2018, p. 1526) and "intimidating", causing them to feel "exposed" and "vulnerable" (Padfield et al., 2017, p. 326). Others spoke about the group culture exerting a "pressure and expectation" (Padfield et al., 2017, p. 326) to express themselves to a competitive standard. Therefore, 'solidarity with peers' is not always a given, or leading to 'connection with others' during group interventions.

1.4 Discussion

1.4.1 Summary of findings

This review aimed to explore inpatients' experiences of specific, named ED IPS interventions. The findings suggest that inpatients being treated for EDs experienced ED IPS interventions as contributing towards their growing senses of 'connection to self', through regaining a healthy autonomy, awareness and acceptance of their cognitions and bodies, and connection with other people (peers and their wider socio-cultural contexts). This is in line with qualitative research findings that ED IPS care can help inpatients rediscover their personal identities, associated with increased awareness and confidence (Smith et al., 2014). Similarly, this review's findings concur with findings that ED IPS care contributes to inpatients' changing perceptions and evaluations of themselves, which improves their self-confidence in responsibly managing their own ED (Wu & Harrison, 2019). Also, current findings align with qualitative review findings that stressed the importance of inpatients integrating their fragmented senses of self, through self-acceptance, connection with other people, and reconstruction of their personal identities (Bezance & Holliday, 2013; Stockford et al., 2019). However, this review takes the findings around 'connection of self' further, indicating that inpatients' journeys to self-connection progress through several stages.

1.4.1.1 Relinquishing control to regaining autonomy, awareness and acceptance of self

This review concurred with previous research and reviews, showing control to be an important aspect of inpatients' experiences of ED IPS (Colton & Pistrang, 2004; de Vos et al., 2017; Halse et al., 2005; Offord et al., 2006; Pemberton & Fox, 2013; Smith et al., 2014; Wu & Harrison, 2019). However, taking these findings further, this review found that ED inpatients go on a journey from relinquishing control to autonomy during admissions.

Some participants found too much autonomy during interventions was uncontained, or hindered their ability to participate. This aligns with evidence that some inpatients find it relieving and containing to relinquish control to the ED IPS (Offord et al., 2006; Pemberton & Fox, 2013; Smith et al., 2014; Wu & Harrison, 2019). It has been argued that this relinquishing of control can enable inpatients to loosen their own internally-imposed control (Palmer et al., 1988). Linked to this, participants in the current review spoke about how relying on the extrinsic control exerted by interventions permitted them the valuable experience of being freed from intrinsic rules. With this, participants in the current review could connect to the self, which was previously hidden by intrinsic rules.

Specifically, this review found that in interventions which imposed extrinsic control through, for instance, frameworks requiring stillness, relaxation and rest, participants could relinquish internal control to get back in touch with their bodies. This resulted in improved emotional wellbeing and physiological discomfort, as well as changing views of their bodies. Ultimately, this meant that inpatients felt increased integration with, compassion towards and ownership of their bodies. As a result of such interventions, participants also reported gaining broader perspectives, increased clarity of mind and reflection, leading to more positive views and attitudes towards themselves and recovery, and core beliefs. The findings around these increasing connections with internal experiences concur with reviews, stressing decreased ED cognitions, insight into self and personal potential, and self-acceptance as signifying ED recovery (de Vos et al., 2017). Also, review findings emphasise the importance of self-acceptance when it came to inpatients' increased self-worth and recovery (Stockford et al., 2019).

Other participants reported valuing interventions permitting autonomy and responsibility, as well as opportunities to openly and honestly express themselves, outside the otherwise pervading extrinsic control of the ED IPS. This concurs with the findings that some inpatients find the control exerted by ED IPS environments distressing (Smith et al., 2014), and a threat to their autonomy that can hinder the exploration of their personal identities (Bezance & Holliday, 2013). Such individuals have also spoken about a preference for

autonomy, taking responsibility for their ED recoveries and feeling empowered throughout their ED IPS care (Colton & Pistrang, 2004; Offord et al., 2006; Smith et al., 2014; van Ommen et al., 2009).

Therefore, inpatients' journey towards self-connection begins with willingly submitting to the extrinsic control. However, with this comes the relinquishing of intrinsic control and rules, allowing inpatients to connect with their internal experiences, and rediscover their autonomous and responsible selves, gradually empowered to reassume control from the ED IPS.

1.4.1.2 Relationships to others and group cultures

This review also found that participants achieved a greater connection to self through connection with other people and their experiences. On the one hand, some participants reported finding it difficult to hear what peers had to say. Linking to group participant heterogeneity, group participation came with the risk of hearing material that participants were not willing, or ready, to consider. In turn, this could have reminded them of earlier times (e.g. childhood experiences), challenging or nostalgic, or of challenging times to come. In addition, these experiences could have contributed to a group culture that some participants found to be exposing and causing feelings of vulnerability. This aligns with previous research and reviews showing that inpatients have found peer relationships difficult due to, for instance, comparisons and competition between them, and the vicarious learning of ED behaviours (Bezance & Holliday, 2013; Colton & Pistrang, 2004; Offord et al., 2006; Smith et al., 2014; Wu & Harrison, 2019). Cumulatively, 'connection to other people and their experiences' during group interventions can, therefore, lead to experiential avoidance if participants are not at similar stages of recovery.

Conversely, other participants experienced a sense of solidarity with their peers, through interactive tasks, and learning about themselves through listening to their peers' stories. This was connected to valuable group cultures that extended into the wider ED environment. Participants in the current review also spoke about connecting to peers through having shared experiences. This mirrors the findings of previous qualitative research, showing that inpatients appreciated the support and understanding of their peers, associated with reduced feelings of isolation (Colton & Pistrang, 2004; Smith et al., 2014; Wu & Harrison, 2019). For the participants in this review, shared experiences went further to broaden their thinking around the causes of EDs, incorporating previously unconsidered societal and cultural factors. Overall, connection to other people and their experiences

contributed to participants' sense of self in relation to others and the wider context. This concurs with the findings of previous qualitative reviews, which showed that inpatients viewed interrelatedness as pivotal to personal identity, self-worth and ED recovery (Bezance & Holliday, 2013; de Vos et al., 2017; Stockford et al., 2019).

1.4.2 Implications

The experiences exposed by the reviewed studies can inform clinical practice for ED IPS interventions. This review concurs with the argument that ED IPS care should be individualised, involving shared decision making (Halse et al., 2005; NICE, 2017). For instance, consideration could be given to whether each patient should be treated individually or alongside their peers, given their readiness and motivation for change. Interventions might consider striking a balance between being structured and allowing autonomy. For example, while inpatients realise compulsory detention in ED IPS environments is sometimes necessary (Tan et al., 2010), they appreciate being allowed to choose whether, and how much, they participate in the ED IPS interventions offered. Those early in their admissions and recoveries will probably prefer structured, focused individual interventions, in line with the broader extrinsic control of the ED IPS. Conversely, inpatients further into their admission and recoveries are likely to benefit from group interventions also, which permit autonomy, personal responsibility and ownership of their recoveries.

Both individual and group formats can benefit from focusing on teaching and practising present-moment awareness and acceptance of internal experiences, which can enable participants to be more open to connection with others. Group interventions can allow opportunities to learn from peers and take part in interactive tasks. However, group facilitators may consider remaining aware that hearing other people's experiences and being part of a negatively-perceived group culture can be hard. Therefore, group participants could be offered a safe, therapeutic space where they can process and regulate the resultant emotions, and reflect on how challenging emotions could be conducive to their recoveries. Moreover, group interventions could benefit from having guidelines, outlined during the initial session, with a focus on sensitivity around disclosure and listening. To minimise guidelines being interpreted as extrinsically imposed, group participants may be permitted to autonomously set these together. This could also facilitate group cultures that are rooted in solidarity and community.

In terms of furthering understanding of the clinical effectiveness of specific, named ED IPS interventions, it would be beneficial for clinicians to continue collecting inpatients'

experiences, exploring what they have found helpful, unhelpful and needing improvement. In addition, quantitative outcome measurement could be administered, measuring ED symptoms over time, using the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008), or co-morbid symptoms (e.g. depression, anxiety or OCD symptoms), and/or a quality of life measure (e.g. Eating Disorder Quality of Life Scale [EDQLS]; Engel et al., 2005). This could contribute to reviews of mixed methods research into specific, named ED IPS interventions in the future.

1.4.3 Limitations and future research

While this review intended to include previously overlooked ED diagnoses and populations, it was limited because it inadvertently repeated the limitations of previous research and reviews. Specifically, studies included in this review did not include ED diagnoses beyond AN, BN and BED, and underrepresented populations such as males and those outside western cultures. This was perhaps inevitable because the majority of ED IPS inpatients are diagnosed with AN (Halmi, 2009) and because of the lack of research into pica and RD (Hoek, 2016). Also, ARFID, OSFED and UFED are relatively new additions to diagnostic criteria; therefore, there is insufficient research into these diagnoses. In addition, with the majority of people diagnosed with ARFID being under 18 years old, the inclusion/exclusion criteria of this review probably excluded studies into the experiences of people with this diagnosis. Also, research is biased towards western females' experiences, leading to an underrepresentation of males and those outside western cultures. Cumulatively, it is not clear whether current results are transferrable to broader diagnoses and populations. However, if reviews of ED literature – both quantitative and qualitative – are to include studies focused on broader ED diagnoses and populations, the research must exist in the first place and, therefore, should be a future research focus.

Regarding the quality of the studies included in this review, over half were rated as low quality. This was mostly because of their inadequate consideration and/or reporting of participants' details, sampling method, researcher–participant relationships, data saturation and analyses, and ethics. Therefore, it remains unclear how accurate the findings of this review are. Future qualitative research should consider appraisal criteria (e.g. CASP), aiming to meet the criteria for high-quality research.

None of the reviewed studies explored inpatients' experiences of psychopharmacological, dietary/nutritional or exercise interventions. Moreover, while this review looked at experiences of a range of psychological approaches, none of the reviewed

studies explored experiences of psychological interventions recommended by NICE (2017). Specifically, there is a gap qualitative research base exploring experiences of CBT-ED, FPT and FT interventions, and future research could focus on each of these psychological approaches, specifically. In addition, 82 per cent of the reviewed studies explored the experiences of group interventions, resulting in a heavy emphasis on themes around connection with other people.

Overall, it remains unclear whether these findings can be transferred to other intervention types, across all MDT disciplines, and those delivered in individual formats. Further research and reviews could also consider focusing on inpatients' experiences of journeying towards regaining healthy autonomy, awareness and acceptance of themselves, and connection with others, possibly generating support for the current findings.

1.4.4 Conclusion

Prevalent across broad population demographics and locations, EDs have been emphasised as complex, biopsychosocial diagnoses with potentially fatal outcomes. ED IPS treatments, with their increasingly holistic, MDT approaches, continue to have high attrition rates and have vast financial implications. Research and reviews have sought to inform the effectiveness of ED IPS but failed to sample a range of population demographics, locations and ED diagnoses, or focus specifically on exploring inpatients' experiences of specific, named ED IPS interventions.

This systematic literature review aimed to critically evaluate the qualitative research exploring adults' experiences of receiving specific, named ED IPS interventions. Collectively, the reviewed studies take previous findings further, showing that inpatients begin a journey towards self-connection through regaining a healthy autonomy, awareness and acceptance of their cognitions and bodies, and connection with other people. These experiences can inform clinical practice for ED IPS interventions, across MDT disciplines, and intervention formats. However, the limitations leave the accuracy and transferability of findings questionable, indicating the need for further research.

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Chapter 2

Empirical Paper

Healthcare support workers' experiences of witnessing and responding to their first few incidences of inpatients' deliberate serious self-harm

Overall chapter word count: 8511 words

2.0 Abstract

Rationale: The occupational stress of witnessing and responding to incidences of deliberate serious self-harm can result in burnout, secondary traumatic stress, and compassion fatigue in healthcare staff. This negatively impacts staff wellbeing and the provision of compassionate patient care. Deliberate self-harm is more prevalent in secure mental healthcare services (MHCSs), such as inpatient psychiatric service (IPS) wards. Previous qualitative research has largely focused on exploring qualified nurses' experiences of working with patients who deliberate self-harm, across a broad range of settings. This is despite unregistered and not clinically qualified healthcare support staff, such as healthcare assistants/support workers (HCASWs), spending more time with patients than nurses, delivering the majority of direct patient care. Evidence has shown that, compared with nurses, such staff have different attitudes towards patients who deliberate self-harm and different emotions in response to working with this patient group, yet they are under-represented in the qualitative literature.

Aims: The aim of the current research is to explore the lived experiences of HCASWs, newly recruited to the role, witnessing and responding to deliberate serious self-harm (DSSH) incidences on IPS wards.

Method: Eleven participants were recruited using purposive sampling. Interviews were conducted and analysed using interpretative phenomenological analysis.

Results: Two superordinate themes emerged from the data as a result of data analysis: (1) 'connection to the horror', describing participants' early experiences of connecting to the reality of the HCASW role and work in IPS, and (2) 'power', describing perceptions of power on the IPS and how this informed HCASWs' responses during DSSH incidences. Each of these superordinate themes was further divided into subordinate themes, which are discussed in relation to existing research.

Conclusion: MHCS have a duty to minimise workplace stress, as well as continuously monitor, train, support and supervise unregistered and not clinically qualified staff who are on the frontline of patient observations and care. This will help minimise their risk of burnout and facilitate wellbeing, enabling them to deliver patient care that is compassionate. This is particularly important for staff who respond to patients who engage in DSSH, which is highly prevalent in secure MHCS. Limitations, implications and future research directions are also discussed.

Keywords: *healthcare support workers, experiences, qualitative, inpatient, deliberate self-harm, phenomenological.*

2.1 Introduction

Reports have exposed the detrimental effect that adverse healthcare service (HCS) cultures in the United Kingdom (UK) can have on staff wellbeing and patient care, across both National Health Service (NHS) and private settings ('The Boorman Review', Boorman, 2009; 'Winterbourne View', Department of Health [DoH], 2012; 'Mid Staffordshire Foundation Trust Public Inquiry', Francis, 2013). Such reports uncovered insufficient training for frontline staff, cultures of patient victimisation, the absence of appropriate supervision and support, and the prioritisation of HCS targets over staff wellbeing and individualised, compassionate patient care (Boorman, 2009; DoH, 2012; Francis, 2013).

2.1.1 HCS staff burnout, secondary traumatic stress, compassion fatigue

'Wellbeing' – sound physical and mental health (Johnson et al., 2017) – is associated with 'burnout' (Johnson et al., 2017) and secondary traumatic stress (STS; Bride, 2007; Figley, 1995) in HCS staff. Burnout arises as a result of chronic workplace stress (World Health Organization [WHO], 2018), characterised by "emotional exhaustion … depersonalisation or disengagement from patients" (Johnson et al., 2017, p. 20). STS is characterised by post-traumatic stress disorder (PTSD) symptoms, such as hypervigilance and fatigue, which can arise in response to hearing patients' traumatic backgrounds and experiences, and engaging in empathic relationships with such patients (Bride, 2007; Figley, 1995). Indeed, The Diagnostic and Statistical Manual of Mental Health Disorders (5th edition; DSM-5; American Psychiatric Association [APA], 2013) states that PTSD symptoms can be triggered by "experiencing repeated or extreme exposure to aversive details of the traumatic events" (p. 271). Together, burnout and STS can contribute to 'compassion fatigue' (CF; Figley, 1995): "weariness brought about by repetitive, empathic responses to the pain and suffering of others" (LaRowe, 2005, p. 21).

Despite efforts to prioritise staff wellbeing (DoH, 2011a, 2011b), workplace stress and burnout remain extensive issues in UK HCS (DoH, 2020; Medical Protection Society, 2019; Royal College of Physicians, 2015). In 2019, NHS staff burnout rates were at their highest for more than a decade (DoH, 2019). This contributes to increasing rates of staff sickness absenteeism (Toppinen-Tanner et al., 2005) and attrition (Buchan et al., 2019), as well as reduced patient safety and care (Hall et al., 2016). This includes diminished 'compassionate care' (Bhutani et al., 2012; Johnson et al., 2017; Perry et al., 2011; Rossi et al., 2012; Upton, 2018), defined here as attempts to alleviate others people's suffering, an extension of 'empathy' (Post et al., 2014).

2.1.2 HCS support staff: Healthcare assistants and support workers

HCS support staff, commonly known as healthcare assistants or support workers ('HCASWs'), have remained "largely invisible to the public and policymakers" (Cavendish, 2013, p. 83) discussing staff wellbeing and compassionate care. This is surprising given HCASWs' vital role (Health Education England, 2015; Royal College of Nursing [RCN] 2015), making up over 400,000 of the NHS's frontline staff (Unison, 2018). Moreover, despite not being professionally registered or clinically qualified, HCASWs deliver the majority of direct, patient care, spending more time with patients than registered nurses, who they commonly work closely with (Bach et al., 2012; Cavendish, 2013; RCN, 2015).

Recommendations have been made to prioritise HCASWs' wellbeing, enabling them to deliver compassionate care (Cavendish, 2013). These suggest that all HCASWs complete a package of standardised, basic training, linked to that of nurses, before working directly and unsupervised with patients. Recommendations also emphasise the importance of appropriate HCASW supervision and support, enabling them to "cope in times of stress" (Cavendish, 2013, p. 34). However, in a survey of 2000 HCASWs, more than half reported still being asked to complete clinical tasks without adequate training and supervision (Unison, 2018), culminating in high levels of stress (Bach et al., 2012; Czuba et al., 2019), burnout (Wallang & Ellis, 2017) and attrition (Cavendish, 2013).

2.1.3 Working in mental healthcare services

Mental healthcare service (MHCS) staff members are subject to increased stress, burnout, STS and CF, compared with other HCS staff (Jenkins & Elliott, 2004; Johnson et al., 2017; McGrath et al., 1989; Meldrum et al., 2002; Ray et al., 2013; Rossi et al., 2012; Thompson et al., 2014). This has been associated with diminished patient safety and quality of care, poor staff wellbeing, increased sickness absenteeism, and high attrition (Johnson et al., 2017). It has been argued that this elevated stress is caused by MHCS care involving, for instance, forcibly detaining patients in IPS, increased violence, and witnessing and responding to patient deliberate self-harm (Letvak & Buck, 2008; Seago et al., 2001).

Rates of deliberate self-harm, defined as "any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation" (National Institute for Health and Care Excellence [NICE], 2013, p. 6), are rising in the UK (Borschmann & Kinner, 2019; McManus et al., 2019; Morgan et al., 2017). This is concerning given that deliberate self-harm is the strongest risk factor for subsequent suicide (Hawton & Harriss, 2007). Unsurprisingly, deliberate self-harm has been emphasised as an urgent priority in the UK

(McManus et al., 2019; Morgan et al., 2017). Deliberate self-harm can be categorised according to (a) whether it is accompanied by suicidal intent, and (b) the degree of resultant harm and how long these effects last, and degree or amount of treatment, or intervention, required (James et al., 2012; Simpson, 2001; Walsh, 2006). As a result, deliberate self-harm behaviours have been described as falling on continuums of severity (James et al., 2012; Simpson, 2001; Walsh, 2006); for instance, from 'low' (harm is minimal, requiring extra observation or minor treatment, or intervention) to 'moderate' (harm is short-term, requiring ongoing treatment, or intervention) to 'serious' (harm is long-term or permanent) to 'death' (James et al., 2012).

According to NICE (2013), MHCS staff play pivotal roles in minimising deliberate self-harm and suicide risk through ensuring safe patient environments, adhering to individualised risk management plans, and close patient observations. In IPS, the majority of this is done by HCASWs (Adams, 2009). Guidance also stipulates that care should be compassionate. However, some argue this is difficult when working with high-risk patients, whose fundamental safety is the priority (Hagen et al., 2017), in IPSs with increased incidences of severe deliberate self-harm (Skegg, 2005), commonly accompanied by suicidal intent (Andover & Gibb, 2010). Wheatley and Austin-Payne (2009) investigated the attitudes of IPS nurses and support staff, such as HCASWs, working with patients who deliberately self-harm. Quantitative data from self-report questionnaires showed that, compared with nurses, support staff held more negative attitudes towards patients who deliberately self-harm, which was associated with increased worry about working with these patients. Exploring this further, qualitative research has contributed to understanding mental health nurses' (MHN) lived experiences of working with patients who deliberately self-harm, as described below.

2.1.3.1 Lived experiences of working with patients who deliberately self-harm on IPS wards

MHNs interviewed by O'Donovan and Gijbels (2006) spoke about finding IPS environments stressful, describing working with patients who deliberately self-harm as challenging, causing frustration. MHNs described processing, accepting and putting aside human, personal emotions, as well as personal values and beliefs, to work with these patients. Also, they explained patient safety as the priority over individualised care, due to the busy and demanding nature of the IPS. In addition, they spoke about the unpredictability of the environment contributing to stress.

In 2007,Wilstrand and colleagues interviewed MHNs who described their thoughts surrounding lacking understanding of patients' problems and did not have the knowledge to care for them. They also spoke about feelings of fear, uncertainty and powerlessness, and having to be constantly alert and aware of patients' potentially fatal actions. Some MHNs described patients as manipulative, trying to control and deceive staff, causing them frustration and anger. As a result, MHNs spoke about closing off personal feelings and becoming increasingly "cold" (p. 75). MHNs also spoke about professional boundaries, setting rules for patients, and following protocols to prevent staff splitting. They also expressed feelings of abandonment by co-workers which contributed to burnout. Because of this, MHNs emphasised the importance of feeling connected to, sharing feelings with, and being validated by, co-workers.

Lastly, MHNs interviewed by Tofthagen et al. (2014) emphasised the importance of understanding individual patients' backgrounds, deliberate self-harm patterns and methods. They considered patients to be vulnerable victims of their pasts, using deliberate self-harm to express their emotions. Therefore, MHNs described encouraging the communication of emotions, trust and therapeutic rapport. However, MHNs also spoke about "unpleasant, provocative, and/or challenging" (p. 5) relationships with patients, describing struggles for control between them.

2.1.4 Rationale, research aim and question

Qualitative research has contributed to understanding MHNs' experiences of working with patients who deliberately self-harm in IPS. However, there has been a significant lack of focus on HCASWs, despite them spending more time in one-to-one observations of patients who exhibit serious deliberate self-harm behaviours. It is possible that HCASWs would express similar experiences to MHNs. Alternatively, because HCASWs report more worry about working with patients who deliberately self-harm (Wheatley & Austin-Payne, 2009), their experiences could be very different. Thus, further research is required to explore the experiences of HCASWs witnessing and responding deliberate self-harm and, in particular, serious deliberate self-harm incidences in IPSs.

With MHNs' experiences of responding to deliberate self-harm altering over time and with experience (Tofthagen et al., 2014; Wilstrand et al., 2007), newly-recruited HCASWs' experiences of witnessing and responding to their first few incidences of deliberate serious self-harm (DSSH) are of particular interest. Such individuals are most likely to reflect organic responses, unchanged by time and experience. Also, finding out about early experiences may

allude to ways HCASWs could be supported to cope with workplace stress, while new to their roles.

Therefore, current research aims to address the gaps in research, using a qualitative methodology to answer the question "What are HCASWs' experiences of witnessing and responding to their first few incidences of DSSH on IPS wards?".

2.2 Method

2.2.1 Research design

In qualitative research, 'reflexivity' can refer to researchers' awareness of epistemological position and how this impacts on research design (Chinn, 2007). This research is rooted in interpretivist epistemology, an idiographic approach to gaining knowledge, seeking to explore, understand and interpret individuals' unique experiences of their social worlds (Ashworth et al., 2019). This denotes the use of a qualitative research design (Ashworth et al., 2019); in concordance with this, this research chose interpretative phenomenological analysis (IPA; Smith et al., 2009).

IPA is based on three theoretical principles: phenomenology, hermeneutics and idiography (Smith et al., 2009). Phenomenology focuses on understanding the parts of phenomena and/or experiences that are unique to the individual (Pietkiewicz & Smith, 2014). This involves the reflexive bracketing of assumptions (Pietkiewicz & Smith, 2014), whereby researchers put aside personal assumptions, expectations, beliefs and experiences surrounding the phenomenon being explored (Chinn, 2007), allowing phenomena to unbiasedly express themselves (Pietkiewicz & Smith, 2014). Also, IPA acknowledges the impact the research process has on participants' realities through hermeneutic circles – researchers interpreting participants' interpretations – generating the need for researchers to reflexively consider their positions in relation to participants (Smith et al., 2009). Therefore, combining aspects of both phenomenology and hermeneutics, IPA is both descriptive and interpretive, emphasising how phenomena appear and allowing them to express themselves, while simultaneously acknowledging the impossibility of an uninterpreted phenomenon (Pietkiewicz & Smith, 2014).

Finally, the idiographic principle emphasises the importance of assigning equal exhaustive exploration and analysis of each participant's perspective, uncovering the similarities and differences between them to produce deeper understandings (Pietkiewicz & Smith, 2014).

2.2.2 Inclusion and exclusion criteria

Participant inclusion and exclusion criteria were agreed based on discussions with the research supervisors, and the clinical psychologist at the recruitment site. The resultant inclusion criteria are outlined in Table 2.1.

Table 2.1

Participant inclusion criteria

Criterion	Inclusion criteria
Occupational qualification	If they were not qualified to one of the following occupational levels, in the UK or abroad: doctor, psychiatrist, clinical/ counselling psychologist, general nurse, psychiatric nurse, occupational therapist.
	If they had previously been, or currently were, a student/trainee of one of the above occupations.
Previous IPS experience	If they had no previous experience working in a similar role in an IPS, in the UK or abroad.
Current HCASW role	If they had worked in their HCASW role for four months or less (including induction week).
	If their HCASW role involved direct contact with patients who DSSH.
	If their HCASW role involved direct witnessing of and/or responding to DSSH.
Other IPS roles	If they were not concurrently working in another inpatient psychiatric unit.
Language	Fluent in English.

The criteria ensured that the research explored HCASWs' experiences of witnessing and/or responding to their first few incidences of DSSH. HCASWs met the inclusion criteria if they were not currently studying towards, or previously qualified in, several specific occupations that commonly come into contact with DSSH (see Table 2.1). In addition, to be included, HCASWs had to have no previous experience working in IPS, and not be concurrently employed in a similar IPS role. Further, HCASWs only met the inclusion criteria if they had been working in their current role for four months, or less, including the induction week. The rationale for the four-month cut-off was based on theories surrounding

organisational socialisation (Fisher, 1986; van Maanen, 1978). Therefore, interviewing HCASWs who had been in the role for up to four months ensured they were still in the early stages of role adjustment, speaking about early experiences of witnessing and/or responding to DSSH.

Lastly, the criteria ensured that participating HCASWs would have enough information to provide about their first few experiences of witnessing and/or responding to DSSH. HCASWs met the inclusion criteria if their current IPS role involved them coming into direct contact with patients who DSSH, and directly witnessing and/or responding to DSSH. Also, participants had to be fluent in English. Eleven participants met the criteria for inclusion and were recruited for the study.

2.2.3 Procedure

2.2.3.1 Ethical processes

This research was conducted in accordance with the British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2018) and the Code of Human Research Ethics (BPS, 2014). Coventry University granted ethical approval in March 2019 (Appendix F). During initial contact with potential participants, it was outlined that taking part in interviews meant participating in a research study, and would not constitute a post-DSSH incident debrief. However, there would be options to discuss appropriate support options following interviews.

2.2.3.2 Materials

In accordance with IPA data collection guidance (Reid et al., 2005), a semi-structured interview guide (Appendix G) was developed alongside the research supervisors. This was informed by IPA principles (Smith et al., 2009), consisting of unbiased, open questions.

2.2.3.3 Recruitment

In IPA, perspectives of specific, homogeneous samples are of interest (Smith et al., 2009). Therefore, this research used purposive sampling, a method that selects participants based on specific characteristics that permit the exploration of the phenomena of interest (Shinebourne, 2011). Participants were recruited from an independent hospital, operating an IPS that consisted of several wards, treating adult females sectioned under the Mental Health Act 1983. Each month a new cohort of HCASWs were recruited and inducted to the independent hospital. The researcher was given permission to contact each cohort and to

provide information about the research to each new cohort. Further, the researcher ensured that any potential participants met the inclusion criteria for the study before arranging interviews.

2.2.3.4 Interview

All interviews were conducted between May 2019 and February 2020, in a private room on the premises where the IPS participants were employed. Before the interviews began, participants were given an information sheet (Appendix H) to review, a consent form (Appendix I) to sign, and a demographics sheet (Appendix J) to complete. Interviews were conducted using the semi-structured interview guide and audio recorded. They lasted between 15 and 80 minutes. Once the interviews were complete, participants were given a debrief sheet (Appendix K) and the IPS's employee support contact details.

2.2.4 Analysis

Transcripts were transcribed verbatim, with all identifiable information being removed to ensure confidentiality. The data obtained was analysed in accordance with the six stages of IPA proposed by Smith et al. (2009; Figure 2.1).

Figure 2.1

IPA stages (Smith et al., 2009)

Stage 1: Reading and re-reading transcript

Stage 2: Initial notes			
Use of right-hand transcript column to make initial notes on:	(a) Content (descriptive, of what participant discussed)	(b) Linguistics (language participant used; e.g. repetitions, metaphors, symbolism),	(c) Early interpretive concepts

Stage 3: Emergent theme development	
Using initial notes, translating them into emergent themes:	"Concise phrase at a slightly higher level of abstraction which may refer to a more psychological conceptualisation" (Pietkiewicz & Smith, 2014, p. 12)

Stage 4: Looking for connections across resultant emergent themes	
Searching for connections across themes; grouping themes into clusters, according to conceptual similarities; assigning each cluster a name.	Resultant clustered superordinate and subthemes listed.

Stage 5: Proceeding to the next transcript/case
Repeat Stages 1 to 4 for each participant transcript.

Stage 6: Looking for patterns across transcripts/cases
Recognising convergences and divergences across participant transcripts.

Appendix L shows an excerpt from the transcript of a participant, illustrating Stages 1 and 2. Appendix M shows part of the list of emergent themes, along with pertaining participant numbers and transcript line numbers, as per Stage 3. In line with Stage 4, Appendix N shows the process of looking for connections between emergent themes through the development of visual maps and mind-maps, emergent themes clustered according to conceptual similarities and assigned a label. This led to the production of a working table of possible superordinate themes and subthemes, added to by repeating Stages 1 to 4 for each participant transcript, recognising the similarities and differences between cases. This culminated in a final list of superordinate themes and themes, discussed in the results section.

Steps were taken to increase the credibility of the study, guided by Yardley's (2015) 'four principles' approach to improving the validity of qualitative research (Table 2.2), endorsed by Smith et al. (2009).

Table 2.2

Four principles for improving qualitative research validity (Yardley, 2015)

Principle	Examples of form each principle can take
1. Sensitivity to context	Sensitivity to relevant theory, literature, empirical data, socio-cultural context, participants' perspectives, ethical issues.
2. Commitment and rigour	Thorough engagement with subject; methodological proficiency/ability; thorough data collection; exhaustive analysis (depth and breadth).
3. Transparency and coherence	Clear and potent description and reasoning; transparent method and data presentation; marriage of theory and method; researcher reflexivity.
4. Impact and importance	Theoretically (enhancing understanding); socio-culturally, and practically (for community, policy and health workers).

This is in accord with the previously mentioned need for IPA researchers to reflexively bracket their personal assumptions, expectations, beliefs and experiences, and to consider their position in relation to participants. This is discussed below in relation to the current research.

2.2.4.1 Study credibility

2.2.4.1.1 Bracketing personal assumptions, expectations, beliefs and experiences.
Although IPA provides no specific step for bracketing assumptions (Giorgi, 2011),
'bracketing interviews' are a known "method used in qualitative research to mitigate the
potentially deleterious effect of preconceptions that may taint the research process" (Tufford
& Newman, 2010, p. 80). In June 2019, a bracketing interview was conducted between the
researcher and a member of the research team. As a result, the researcher became aware of
some assumptions stemming from previous work as an HCASW in an IPS, which required
bracketing to prevent biasing of data collection and analysis (see Appendix O).

2.2.4.1.2 Consideration of researcher's position. In interpretive methodologies,
such as IPA, researchers are expected to explore their personal position in relation to
participants, as well as research-participant relationships and dynamics (Chinn, 2007; Maykut
& Morehouse, 1994; Råheim et al., 2016). Part of this involves the consideration of 'insider'
and 'outsider' researcher positions. Insiders are known for "sharing the characteristic, role or
experience under study with the participants" (Dwyer & Buckle, 2009, p. 55), while the latter
share few experiences with participants (Ross, 2017). However, it has been argued that the
insider–outsider dichotomy oversimplifies the possible positions: just because researchers
consider themselves part of the same 'culture' of the participants being studied, this does not
mean they are part of the same 'subculture' (Asselin, 2003). With this in mind, the researcher
assumed the position of 'partial insider', as opposed to a 'total insider' (Chavez, 2008),
because, although they were possibly part of the same, broad IPS culture, they were possibly
not part of the same, specific IPS subculture as participants. Having reflexive knowledge of
this position helped the researcher remain aware of their biases, and open to the potential
uniqueness of participants' experiences.

2.2.4.1.3 Data analysis reliability checks. An additional researcher also coded a
sample of transcript, which was compared with the corresponding excerpt and codes of the
original researcher to improve the reliability of data analysis.

2.2.4.1.4 Data analysis audits. Data analysis by the researcher was regularly audited
by other members of the research team who were more experienced in IPA methods.
Specifically, during the data analysis, mind-maps of the connections between emergent
themes, as well as resultant, evolving lists of superordinate themes and themes, and

similarities and differences across participant transcripts were discussed. This resulted in ongoing amendments to the original clusters of emergent themes, so that the resultant superordinate themes and themes more accurately reflected the participant data.

2.2.5 Participants

Table 2.3 lists the characteristics of the 11 participants included in this research, each assigned a pseudonym to preserve their anonymity.

Table 2.3

Participants' characteristics

Participant	Age (years)	Gender (M/F)	Ethnic group	Part/full -time	Weeks in role	Trained in DSSH (Y/N)	Restraint trained (Y/N)
Daisy	22	F	White British	Full-time	1	N	N
Katy	22	F	Any other Asian background	Part-time	1	N	N
Jack	22	M	White British	Full-time	<1	Y	N
Becca	25	F	Indian Asian	Part-time	<1	N	N
Joann	26	F	White British	Full-time	<1	N	N
Ellie	26	F	White British	Full-time	<1	Y	N
Ann	20	F	African	Full-time	8	Y	Y
Amanda	24	F	African	Full-time	6	Y	Y
George	30	M	White British	Full-time	4	Y	Y
Susann	30	F	African	Full-time	2	Y	N
Elliot	30	M	White British	Full-time	8	Y	N

<div align="center">**2.3 Results**</div>

Two superordinate themes emerged from the data: (1) 'connection to the horror' and (2) 'power', each subdivided into subordinate themes (see Table 2.4).

Table 2.4

Superordinate and subordinate themes

Superordinate theme	Subordinate themes
1. 'Connection to the horror'	1a. "It sounded like it was a war zone."
	1b. 'Being on guard in the war zone'
	1c. 'Adapting to distress'
2. 'Power'	2a. "She's chosen you as a victim."
	2b. "There's keeping them safe, and then there's aiding in their recovery."
	2c. "In it together"

2.3.1 Superordinate theme 1: 'Connection to the horror'

The superordinate theme 'connection to the horror' describes participants' early experiences of the reality of the HCASW role. It comprises three subordinate themes: (a) "It sounded like it was a war zone", (b) 'being on guard in the war zone', and (c) 'adapting to distress'.

2.3.1.1 Subordinate theme 1a: "It sounded like it was a war zone"

The majority of participants described their new colleagues recounting past DSSH incidences during induction and initial shifts, the content of which was extreme and "of a gruesome nature" (Susann: 682). Ellie described feeling shocked at hearing such accounts, likening preparing for the role to preparing to watch a gruesome horror film.

> *"You know, some things you think 'Oh it's awful, why would you do that?'… but you're meant to have that reaction, I guess. The only way I can properly prepare myself for it is thinking it's going to be like a horror film."* (Ellie: 497–503)

Joann compared colleagues' accounts to: "… when you … hear on the news about a war zone" (615–616), echoed by George:

"During my induction we were flooded with information of 'this is what could go wrong' and this is 'what you need to be aware of' and it sounded like it was a war zone ... it was obviously to put people on guard." (George: 317–330)

This describes "flooded" with warnings during induction, which George perceived to be aimed at preparing them.

Colleagues' accounts were viewed both positively and negatively. Ellie reflected that hearing accounts lessened the shock of witnessing DSSH for the first time, stating it was "not necessarily shocking", as they had been "quite well briefed" (160–161). However, as narrated by another participant:

"So, they were preparing us for the worse, which is good, but it's not always a good thing because it kind-of scares people off ..." (Amanda: 86–87)

This reflection demonstrates that sharing experiences of graphic DSSH incidents can cause fear, later referred to as "scare-mongering" (George: 864), which some stated led to peers leaving during induction. As a result, the majority of participants questioned their ability to cope with witnessing DSSH, being able "handle it", questioning "Is this for me?" (Amanda: 114–124).

2.3.1.2 Subordinate theme 1b: 'Being on guard in the war zone'

This subordinate theme describes participants' initial experiences of directly witnessing and/or responding to DSSH incidences. Some participants emphasised the difference between hearing about DSSH and witnessing it for the first time:

"It's almost, 'Okay this is real now… this isn't a training session ... this is a job'. This is ... what you could be doing." (Joann: 537–543)

Other participants said that, despite colleagues' accounts, witnessing DSSH made them feel "scared" (Amanda: 205) and was "still shocking to see" (Jack: 102), which is consistent with Daisy's description:

"I guess definitely shock just seeing it because you hear all about it and you know what goes on but, yes, seeing it for the first time obviously isn't very nice ..." (Daisy: 110–112)

Participants described how, experiencing patients as unpredictable and DSSH occurring without warning, they needed to remain vigilant:

"They can be really happy and nice and, then, all of a sudden: boof! And you're like, 'Woah! Where did that come from?'." (Susann: 650–653)

The word "boof!" was accompanied by Susann signalling an explosion with their hand. This links to descriptions of patients as having the potential to suddenly "explode" (Jack: 437), or having to be "ready for an explosion" (Jack: 349).

Most participants spoke about the "unpredictability of it all" (Joann: 90), meaning patient DSSH, and witnessing DSSH causing physiological arousal, such as "panicking, really, just panicking … actually shaking" (Amanda: 266–267), likened to having just done a "bungee jump" (George: 149). Katy described an ongoing state of alertness, stating "I had to be on my toes" (41), in line with Ann's description:

"You know when you're really anxious and you get that really weird feeling in your stomach? It's like that most of the time." (Ann: 339 342)

All of the participants spoke about the difference between shadowing colleagues and being one-to-one with patients. They equated the latter to not being able to rely on the immediate presence of more "capable and switched on" (Jack: 551) staff members:

"If my reaction's not adequate there is somebody literally stood right next to me who knows exactly what they're doing. But, when I'm on my own, I'm going to be responsible for the first response." (Jack: 551–555)

Most participants feared their first response might unintentionally escalate the patient's DSSH:

"For me it was sort of like concern for them, panic that what I do might be wrong or make things worse ... I don't want to do something that might hurt them more, or push them to do something that hurts." (Jack: 60–64)

Alongside this, some participants expressed they would not be able to "live with [their] inaction or wrong action killing someone" (Ellie: 551). Some of this fear stemmed from colleagues' accounts:

"It really scares everybody because then you get on the ward and you don't want to talk to anyone because you're just afraid you'll say something and they'll just self-harm. Because all you've been told is ... bad things happen." (George: 534–538)

Some participants spoke about the spoke of difficulty of knowing how to respond to DSSH without knowledge of individual patients:

"You don't know ... the right things to say as the right thing to say to someone could be completely wrong for someone else." (Daisy: 430–432)

Most participants spoke about coping with responsibility in terms of being able to "always get help" (Ellie: 455) and "rely on the team" (George: 623) as "back-up" (Elliot: 664–667), even when they were one-to-one with patients.

2.3.1.3 Subordinate theme 1c: 'Adapting to distress'

Participants discussed how DSSH was seemingly being viewed as a normal, everyday occurrence by colleagues. Some participants described shock at their colleagues' nonchalant attitudes towards serious DSSH incidents, and their colleagues' lack of outward reaction:

"Everyone was still sat in their chairs and not even reacting ... no one even looked." (George: 721–722)

"There was a thing I found quite shocking: just how normal it was, like, "Oh such-and-such tied a ligature yesterday and, you know, their face was purple" and then, "Oh ... what's for lunch?" (George: 338–340)

Participants also spoke about learning to manage their inward emotional and physiological responses to witnessing DSSH in two different ways. First, joining colleagues in coming to view DSSH as normal, detaching from empathy and compassion. Second, remaining in touch with internal responses, but keeping them inside and not outwardly showing them.

Regarding the former, some participants described expecting having to "have a degree of detachment" (Ellie: 507) from human emotions to avoid becoming "emotionally drained" (Amanda: 339; Susann: 393). Susann reflected that, over time, if they did not detach to a degree, they expected becoming "too emotional to actually work" (411). Joann emphasised the importance of finding a middle ground between remaining in touch with, and detaching from, empathy and compassion:

"I think it's just a difficult balance. But, at the end of the day, you're, you're just human and … if you, actually, can really just draw a line and be like, 'No, that that's them and that's me', maybe psychology and caring isn't kind of your area of expertise." (Joann: 405–418)

However, Elliot emphasised that, even when detached from empathy and compassion, "you get the adrenalin rush no matter what" (802), some staff simply learning to hide their automatic responses from being outwardly observable. This is in line with Amanda's description of being "taught" by colleagues to "wear a mask" (794) to hide nervousness and fear of being exposed in front of patients:

"I was nervous at first and I didn't want to show it to the patients because I don't want them to know that … I was very scared." (Amanda: 202–205)

Others spoke about "put[ting] on this face" (Daisy: 145), or a "poker face" (Susann: 832), to hide reactions.

2.3.2 Superordinate theme 2: 'Power'

The superordinate theme 'power' describes participants' experiences of power during early incidences of witnessing DSSH. It is subdivided into the following subordinate themes: (2a) "she's chosen you as her victim", (2b) "there's keeping them safe, and then there's aiding in their recovery", and (2c) "in it together".

2.3.2.1 Subordinate theme 2a: "She's chosen you as a victim"

This theme describes participants' perceptions of who, between patients and staff, is in power on the IPS, and participants' experiences of who – staff or patients – holds power. Some participants described hearing from colleagues that patients are in a powerful position and deliberately victimise staff:

> *"It sounded like the patients are out to get you and it's almost a prison setting where they will watch you watching them and, when you blink, they will do something … they're very scheming."* (George: 325–329)

This likens colleagues' accounts to prison storylines: patients teaming up to collectively overpower staff. George reflected that one patient had been described as "a schemer who was manipulating staff" (219), emphasising staff as victims:

> *"She was mentioned a lot to the new people … 'as a new person, she's going to look for you as weak blood … and she'll be ready … because she's chosen you as a victim'."* (George: 478–487)

Here, the use of the word "blood" links back to analogies of horror films and war zones, and to Amanda's recollection of colleagues describing patients "as if they were animals" (721).

Some participants expressed views about patients using DSSH to exert control over staff "because they know it warrants a response" (Jack: 109). Elliot reported finding these patients to be "annoying and frustrating" (725) as they monopolised staff, adding:

> *If you break promises then I'm going to do this … trying to prove a point kind of way … it was a definite deliberate act, an act of defiance."* (Elliot: 759–771)

This description contrasts with other participants, who expressed experiencing DSSH as a coping mechanism:

> *"She's not doing it because she's mean … she's probably doing it as a reaction to a million other things that have happened in her'."* (George: 226–230)

From this reflection, it seems that not all participants viewed patients as intentionally victimising. This supports the majority of participants' views of patients as powerless "victims" (Katy: 18) of circumstance, such as "trauma from the past" (Susann: 246–247), or not having "had the upbringing they needed" (George: 87–88):

> *"When you hear the history that has happened you always think, I felt like,*
> *'Oh, I can see that child in them who should have been helped long ago'."*
> (Susann: 310–313)

Childlike descriptions of patients were echoed by other participants. For instance, "I'll go down to their level" (Becca: 143), when describing how they would speak to patients, and "She was supposed to be weaned off the support she needed" (George: 844), the word "weaned" having childlike connotations.

2.3.2.2 Subordinate theme 2b: "There's keeping them safe, then there's aiding in their recovery"

This theme describes how participants' perceptions of power informed contrasting responses to DSSH, either with (a) compassion or (b) according to professional protocols. Several participants referenced this dichotomy, for instance:

> *"I've got to have that connection with them otherwise you're not going to be able to*
> *help them … if you've got that good rapport with people … have a chat … de-escalate*
> *stuff … as opposed to a stand back, cold professional."* (Elliot: 473–491)

Elliot highlights the difference between connecting and building rapport with patients, responding through verbal de-escalation, and standing back from emotions, responding to DSSH through protocols, such as physical restraint.

The majority of participants described having empathy for patients, contributing to compassionate care. Participants expressed feeling "sadness" (Amanda: 713), "heartbreak" (Susann: 161), and "concern" for patients, "wanting to help them more" (Katy: 42–43). Susann highlighted the importance of forming attachments with patients as part of developing empathic understanding and compassion:

"If I bond with [patients] … you can understand them … and then they do something, like self-harming or… they harm another staff … you just feel like, 'I'm here for you'." (Susann: 953–958)

This quotation speaks of providing an unconditionally compassionate presence for patients, referred to as going through emotions "with" patients (776). Such responses seemed more common in participants who viewed patients and staff to be similar human beings "both just trying to relate to each other" (George: 1847–1848). For Ellie, Ann, George and Susann, compassionate responding came from having similar backgrounds to the patients. Ann commented that "personal experience … it helps you … understand where [patients] are coming from" (53–54). However, George described compassionate responding as being inherent and instinctual, not requiring personal experience:

"The human touch, the compassion thing … you shouldn't need to know how to be a human being to somebody else." (George: 1910–1911)

However, some participants commented on being afraid to follow their compassionate instincts when responding to DSSH:

"Half of you is just going, 'Rush over, grab her, take her away, like are you okay?' And then half of you is like, 'Is that what you should do?'" (Jack: 421–424)

Jack is speaking about the instinctual urge to compassionately intervene being at odds with what staff "should" do, referring to professional protocols (e.g. waiting for another staff member before physically intervening).

Other participants spoke about physical restraint as a professional care response ensuring basic survival and safety:

"I guess, the holding bit is the last resort if they can't talk them down first but, yes, their safety is [the] priority." (Daisy: 83–84)

Here, the word "hold" is used to described restraint, perhaps to bring an element of compassion to a forceful act. However, George described there being "no sort of

compassion" behind restraint – it is about "controlling the act [of DSSH]" (332–333) – likening staff to "security guards" (328), synonymous with using force to assert power.

2.3.2.3 Subordinate theme 2c: "In it together"

This subordinate theme describes participants' experiences of the power of the collective staff team response to DSSH. Specifically, of becoming trained to restrain patients as facilitating their integration into a powerful staff team, responding collectively according to professional protocols. Most participants spoke about only feeling useful to the team once they could restrain patients:

> *"[Once restraint trained] I can be more helpful, which is good. At the minute I feel useless most of the time … just sat there … I can help everybody else … help them cope and distract them or that kind of stuff, but I can't physically help [restraint patients]."* (Elliot: 346–358)

This was echoed by Jack, who described feeling "useless" because they had not "done any restraint training" (291–293), while Katy reported wanting to be restraint trained so they could "make a difference as a member of the team" (127–128). George also spoke about their initial restraint as being like an initiation into the team:

> *"So I think that, for my peers, as well, who all started at the same time … that's been a, kind of, rite of passage."* (George: 446–453)

Some participants spoke about joining in with restraints as aiding team bonding:

> *"Because, if I was a bystander again, like I was pre-restraint training, I wouldn't have been able to … feel that familial bond."* (George: 1572–1574)

Here, a comparison is made between being outside the bond of the staff team and being inside it through collectively restraining patients.

The importance of team allegiance was echoed by all participants as a way of coping. George described going through DSSH incidences "all together" (1570), while Ann reflected:

"They'll just ... ask me if I'm all right, if I can cope, things like that ... they just reassure me." (Ann: 735–741)

This describes the team as a source of support and reassurance, echoed by Amanda who described the team as making them feel "much more confident" (482) in responding to DSSH. George described how "it's not about the problem itself but the network that responds to it" (2055–2056). George also emphasised that "if [their] team were not supportive" they think they would "have quit" (617), but that this was not the case across staff teams:

"There's a big disparity at the moment between the two shift patterns. In terms of ... their ability to be a cohesive unit for each other and for the patients. I'm not sure I would have coped had I started with the other team." (George: 1873–1878)

George emphasised thinking that they would not have coped with witnessing and responding to their first few DSSH incidences if they had been assigned to the team on the opposite shift pattern, which was perceived to be less cohesive.

2.4 Discussion

2.4.1 Significance of main findings

This research aimed to explore the lived experiences of newly-recruited HCASWs witnessing, and responding to, their first few incidences of DSSH in MHCS IPS. It was hoped this would inform how new HCASWs can be supported to cope with the elevated stress of working with patients who DSSH (Letvak & Buck, 2008; Seago et al., 2001). In turn, this could prevent burnout, STS, CF and diminished wellbeing, as well as sickness absenteeism and high attrition rates, and improve compassionate care delivery (Johnson et al., 2017).

2.4.2 Discussion of main findings

Two themes emerged as a result of the analyses, which are discussed here in relation to the research described earlier.

2.4.2.1 Superordinate theme 1: 'Connection to the horror'

This theme conveys journeys from fear of the unknown to fear of patient unpredictability, from being reliant on the presence of other staff members to being

responsible for one-to-one patient observations, and towards either detaching from, or hiding from others, their inward responses to DSSH. Using the analogies of horror films and war zones, participants found the extreme content of colleagues' accounts of past DSSH frightening, causing them increased physiological arousal. This is in line with DSM-5 criteria stating that PTSD symptoms (e.g. hypervigilance) can be triggered by "experiencing repeated or extreme exposure to adverse details of the traumatic events" (APA, 2013, p. 271). Also, it links to STS theories stating that PTSD symptoms can be developed in response to hearing others people's traumatic experiences (Figley, 1995). MHNs in previously described research do not mention colleagues' accounts; this could be because MHNs are not subjected to the same accounts, or because the focus of past research was not MHNs' early experiences.

Participants contrasted hearing colleagues' accounts with directly witnessing their first DSSH incidences, the latter causing comparatively heightened shock, fear, panic and shaking. Similarly, community psychiatric nurses (CPNs) have described feeling shocked and alarmed by deliberate self-harm and the resultant injuries (Thompson et al., 2008). Participants described their fear of the unknown developing into fear of patients' explosive unpredictability, accompanied by ongoing states of alertness. Not only is this in line with more persistent symptoms of PTSD (e.g. hypervigilance; APA, 2013), it also is supported by MHNs who described unpredictable IPS environments and patients' potentially fatal deliberate self-harm behaviours adding to alertness, anxiety and fear (O'Donovan & Gijbels, 2006; Wilstrand et al., 2007).

Participants also feared being one-to-one with patients, thinking they lacked adequate training to provide the first DSSH response. Although not mentioned by previously described MHN research, broader research shows that more junior staff members, with less risk management training, exhibit more hesitance around talking to suicidal patients for fear of unintentionally causing them distress (Awenat et al., 2017). Similarly, participants spoke about unintentionally escalating patient DSSH, leading to inaction because of the fear of repercussions. Participants also described predictions around being blamed for patient fatalities, alongside unmanageable guilt and job loss. This fear and hesitance were heightened by colleagues' accounts of past inadequate responses to DSSH resulting in patient fatality. CPNs in research by Thompson et al. (2008) also described fearing the possibility of being blamed for patients' suicide. Indeed, MHCS staff have reported that organisations prioritise the location of blame after patient suicides, as opposed to staff wellbeing (Awenat et al., 2017).

Participants emphasised that knowing each patient's preferred responses to DSSH made them feel more confident to respond. This echoes the MHNs in the research by Wilstrand et al. (2007), who believed that understanding patients would improve care quality. However, participants emphasised that, although they were given a high volume of abstract information about individual patients, they were not allowed adequate time to process this and learn who the information applied to. Participants also said they coped with responsibility by knowing they could summon help from other staff. Although not mentioned by MHNs, this echoes the experiences of CPNs who spoke about the burden of responsibility being ameliorated by shared responsibility with co-workers (Thompson et al., 2008).

Participants also spoke about coping by detaching from emotions, such as empathy and compassion. This is in line with previous research, with MHNs speaking about putting aside human, personal emotions (O'Donovan & Gijbels, 2006), and becoming "cold" (Wilstrand et al., 2007, p. 75). Participants spoke about detaching to avoid emotional exhaustion, linking to Figley's argument that STS can arise from developing empathic relationships with patients who have been victims of traumatic experiences (Figley, 1995). However, it has been argued that detaching from emotions is maladaptive and a warning sign for STS and the resultant CF (Dunkley & Whelan, 2006; Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995). However, automatic, fight-or-flight physiological arousal seemed to be harder to detach from, or habituate to. This is similar to MHNs who regularly referred to ongoing physiological arousal (O'Donovan & Gijbels, 2006; Wilstrand et al., 2007). However, CPNs have described decreasing anxiety over time due to either desensitisation, habituating to physiological arousal, or burnout (Thompson et al., 2008). That said, working in the community might mean the deliberate self-harm is less frequent and/or severe than that witnessed and responded to by MHNs; therefore, the same desensitisation and burnout may not apply to MHNs or HCASWs working in IPS. Instead, participants describe having to hide any outward reactions to DSSH that could expose them in front of patients.

2.4.2.2 Superordinate theme 2: 'Power'

This theme describes a dichotomy of perceptions of who holds power on the IPS, patients or staff, and how these perceptions inform a dichotomy of DSSH responses. It also describes the power of the collective staff team response to DSSH. Participants spoke about the dichotomy between understanding patients as powerful, manipulative schemers and powerless victims, neither understanding patients and staff as equals. Some participants recalled colleagues' accounts describing patients as manipulative and scheming. This links

back to adverse HCS staff cultures, said to encourage staff victimisation of patients and assertion of power over them (Boorman, 2009; DoH, 2012; Francis, 2013). Similarly, nurses in previous research have described patients as manipulative, using deliberate self-harm to control staff (Thompson et al., 2008; Wilstrand et al., 2007). As outlined by Tofthagen et al. (2014), this can culminate in power struggles between patients and staff.

Other participants described patients as powerless victims, echoing MHNs who described deliberate self-harm as a coping mechanism to express emotions, as opposed to a control mechanism (Tofthagen et al., 2014). However, evidence shows the views and beliefs of HCS staff engaging in ongoing empathic relationships with trauma victims are subject to change through a process known as 'vicarious traumatisation' (Pearlman, 1999; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Therefore, participants' views of power could change over time, with the potential for all HCASWs to view patients as equal to staff, linked to more compassionate responding.

Participants emphasised the difference between responding to DSSH in (a) an individualised and compassionate manner and (b) a professional manner, ensuring safety and security. This dichotomy echoes the argument that compassionate care can be difficult when the immediate priority is ensuring patients' safety (Hagen et al., 2017). Also, it concurs with MHNs who emphasised the difference between individualised patient care and patient safety, the former often at the expense of the prioritised latter (O'Donovan & Gijbels, 2006).

Some participants described compassionate care, in the form of instinctual caring for patients, building connections and rapport, and engaging in verbal de-escalation. This seemed to be related to viewing patients as equal human beings to themselves, and remaining in touch with empathy and compassion. Some participants described how gaining more information about patients' backgrounds informed more compassionate responses. This is in line with MHNs, who stated knowing individual patients' backgrounds enabled empathic understanding and compassion (Wilstrand et al., 2007). It also echoes MHNs' non-judgemental and empathic approach to care, facilitated by knowing patients' backgrounds (Tofthagen et al., 2014).

Participants often discussed how having personal experience of DSSH can facilitate empathic understanding of patients. However, it has been shown that those with higher baseline empathy levels are at increased risk of CF (Turgoose & Maddox, 2017). Linking back to responsibility, participants felt conflicted when having to decide whether to respond according to compassionate instincts, rooted in inherent human nature. This was in case their

actions deviated from stipulated professional protocols and caused them to be accountable for causing further harm.

Other participants described more professional approaches to care, aimed at ensuring safety and security. This seemed to be associated with standing back from personal emotions, and the need to reassert power over manipulative, scheming patients through professional protocols, such as restraint. Again, this links back to adverse staff team cultures, which arguably contribute to staff victimisation of patients and the assertion of power (Boorman, 2009; DoH, 2012; Francis, 2013). In addition, it could be linked to elevated stress, burnout and STS causing CF (Figley, 1995) and the resultant decrease in compassionate responding. Some participants expressed their eagerness to be restraint trained as a rite of passage and ways for them to be useful to, and bond with, other staff. In contrast, MHNs in research by Tofthagen et al. (2014) spoke about restraint negatively, as contributing to power struggles between patients and staff. Again, it could be that, with more experience, participants' views of restraint alter to mirror those of MHNs, or that there are differences in the perceptions of power between HCASWs and MHNs due to their different training and experience.

The importance of co-worker support and team cohesiveness emerged in both previous (O'Donovan & Gijbels, 2006; Wilstrand et al., 2007) and current research as facilitating coping and improving confidence. However, team cohesiveness is not a given, highlighting that different team subcultures exist within wards. The MHNs in research by O'Donovan and Gijbel (2006) and Wilstrand et al. (2007) spoke about a lack of co-worker support and feeling abandoned by co-workers as contributing to burnout and superficial care. This accords with broader research showing that co-worker support is related to lower burnout in IPS nurses (Jenkins & Elliott, 2004).

2.4.3 Implications

The findings from the current research could inform methods of supporting new HCASWs cope with the stress of working with patients who DSSH, which could help reduce staff burnout, STS, CF, sickness absenteeism, and attrition, and improve staff wellbeing and compassionate care. Before HCASWs begin IPS work, they would benefit from receiving information about the role, including DSSH. Any accounts of past DSSH should be presented as objective, reflective case studies. Those is managerial positions could consider ways of discouraging a culture of shocking or frightening new recruits with subjective accounts, as this can result in them leaving the role prematurely. Discouraging such a culture could also facilitate honest and trusting relationships between HCASWs and their new colleagues.

Before working one-to-one and unsupervised with patients, it could be mandatory for HCASWs to complete recommended basic, standardised HCASW training (Cavendish, 2013). Training provided could take a trauma-informed approach, encouraging HCASWs to understand patients and staff as equals. This could move HCASWs away from understanding patients as either powerless victims, needing pity and rescuing by staff, or manipulative schemers, needing staff to reassert power over them. Understanding patients and staff as equals could inform more compassionate HCASW responding. Helping this process further, HCASWs could be provided with, and given time to process, summary information on each patient, detailing relevant facts about their background and DSSH behaviours, as well as triggers and preferred responses. This is in the interest of individualised care, helping HCASWs feel confident to compassionately respond to each patient's DSSH. HCASWs should also be introduced to each patient so they know who the information applies to.

It might also be beneficial for ward managers to look out for specific factors putting staff at increased risk of burnout: for instance, those with pre-existing symptoms of depression or anxiety, or those with little clinical experience (Dunkley & Whelan, 2006; Lerias & Byrne, 2003; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995). Debriefs can ameliorate the negative impact of the stress associated with DSSH incidences in IPS (NHS, 2019); therefore, those in management positions could consider ways to implement these debriefs routinely, closely following incidences. If IPS wards are too busy to facilitate this, on-site Clinical Psychologists could offer HCASWs regular, drop-in supervision slots, in line with Cavendish (2013). Also, staff might benefit from opportunities for staff team supervision/peer support to reflect, objectively, on DSSH incidences. In addition, staff teams would benefit from regular opportunities to participate in team-building activities away from the IPS. Here, those in management positions might remain aware of the potential for team cohesiveness to become a 'team versus patients' culture. Reflective practice groups may help teams consider such dynamics and collective, compassionate DSSH responses. Lastly, the details of staff support structures could be made readily available, with transparent whistle-blowing measures to report malpractice, fostering cultures of openness and honesty.

2.4.4 Research limitations and future research

Current research findings should be considered in the light of certain limitations. The inclusion and exclusion criteria did not exclude participants with personal experience of DSSH. Excluding these participants would have produced a more homogeneous sample, speaking specifically about their first few experiences of DSSH during their lifetime. In

addition, research participation was voluntary; therefore, the participants might have been motivated to participate (Salkind, 2010) to please their new employers, or to express grievances. Although steps were taken to improve researcher reflexivity, the possible impact of researcher bias (Horsburgh, 2003) and researcher–participant relationships or dynamics (Råheim et al., 2016) must still be considered. Moreover, the results are not designed to be generalised to wider populations (Smith et al., 2009). That said, it is hoped that the research process has been detailed to allow the transfer of findings (Shenton, 2004). Future research could replicate this study with HCASWs working on other IPS wards. Alternatively, mixed methodologies could be applied to further understand HCASWs' quantifiable attitudes, views and emotions, or burnout, STS, vicarious trauma and CF, as well as risk and protective factors of these, alongside lived experiences.

2.4.5 Conclusion

In the light of reports highlighting adverse HCS cultures, culminating in poor staff wellbeing and diminished compassionate care, the aim of the current research was to explore the lived experiences of newly-recruited HCASWs witnessing, and responding to, their first few incidences of DSSH in MHCS IPS. With previous research focusing on the experiences of MHNs, this research has generated new knowledge by focusing on HCASWs, a previously overlooked population, and their organic experiences of responding to DSSH, unaltered by clinical qualification training and experience. Findings build on themes from previous research but go on to fits themes together reveal the journeys HCASWs embark towards fearing the unpredictable, being confidently responsible for one-to-one patient observations and first responses to DSSH, and either detaching from, or hiding from others, their inward responses to DSSH. Moreover, findings allude to dichotomous perceptions of who holds power on the IPS, and how these inform dichotomous DSSH responses, individualised and compassionate, or professional and protocoled. The latter of these responses, and specifically physically restraining patients with other staff, was also revealed for the first time to bring about feelings of usefulness and connectivity to colleagues and the staff team.

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Chapter 3

Reflective Paper

A reflective formulation of my research journey

Overall chapter word count: 3449 words

3.0 Introduction

At the end of training, trainee clinical psychologists (CPs) should be reflective scientist practitioners (British Psychological Society [BPS], 2019a), "cognisant of the importance of self-awareness and the need to appraise and reflect on their own practice" (BPS, 2008, p. 8). But reflection does not stop then: the BPS (2010) indicates areas for continual CP personal and professional development, with reflection as a clinical leadership skill that CPs must continue to develop and demonstrate in their research and clinical practice.

It is difficult to define 'reflection' and 'reflective practice' (Fisher et al., 2015) because they are conceptual and without a theoretical basis (Mann et al., 2009). Stedmon and Dallos (2009) argued that reflection is the application of attention and awareness to personal thoughts, memories, emotions and physiological sensations, occurring in the present moment. 'Reflexivity', then, is the process of consciously using theory to further evaluate present-moment reflections (Stedmon & Dallos, 2009).

In qualitative research, 'reflexivity' also refers to an understanding of personal and epistemological positions, inclinations and wishes, and the impact these have (Chinn, 2007). The term is mostly used in social research using interpretive methodologies (Chinn, 2007), such as interpretative phenomenological analysis (IPA), which I used in my empirical research, that are open to researcher bias (Horsburgh, 2003). Indeed, qualitative researchers must reflexively explore researcher–participant relationships and dynamics (Råheim et al., 2016).

In this chapter, I will unite my inner scientist and practitioner, using a clinical approach – acceptance and commitment therapy (ACT) – to formulate reflections (thoughts, memories, emotions, physiological sensations which were assigned attention and awareness) that occurred during the empirical research. I will then reflexively evaluate these, drawing out the themes occurring in my reflections. The rationale for applying a clinical approach to the process of research is rooted in a BPS (2019b) recommendation. Specifically, CPs should be able to demonstrate the skilled application of a cycle of assessment, formulation, intervention and evaluation to a range of different problems and situations.

3.1 Acceptance and commitment therapy formulation

ACT is a clinical approach that does not aim to disprove, alter or harness challenging internal experiences (e.g. thoughts and feelings; Arch & Craske, 2008). Instead, it aims to improve quality of life in spite of them (Harris, 2009; Hayes et al., 2012; Kanter et al., 2006) through increasing psychological flexibility: the transdiagnostic, core mechanism of change

(Hayes et al., 2006; Levin et al., 2014; McCracken & Vowles, 2014; Venta et al., 2012). This is characterised by (a) openness, achieved through acceptance of internal experiences, and defusing from cognitions, (b) awareness, achieved through contact with the present moment and (c) activeness, achieved through commitment to values-based behaviours (Harris, 2009).

ACT interventions, aiming at increasing psychological flexibility, include acceptance and mindfulness exercises, and setting goals for committed action, based on personal values (McCracken & Vowles, 2014). In turn, psychological inflexibility, characterised by being 'closed', 'distant' and 'passive', decreases. As a welcome by-product of this, challenging internal experiences may also decrease (Greco et al., 2005). In ACT, formulation can be aided by the 'hexaflex of psychological inflexibility', a diagram depicting the six transdiagnostic core processes of ACT and how they are related (Harris, 2009). This hexaflex is applied to my reflections in Figure 3.1 and described below.

Figure 3.1

Hexaflex of psychological inflexibility

Avoidance of challenging internal experiences through:
- Avoidance of unpleasant memories of working as an HCASW on an IPS.
- Avoiding planning research, leading to short-term denial and relief.
- Avoiding checking emails.

Fused with challenging internal experiences:
- **Past memories about:**
  - Unpleasant experiences working as an HCASW on an IPS.
- **Present feelings of:** overwhelm, incompetence, sadness, worry, exhaustion, frustration, panic.
- **Present thoughts of:**
  - Self-critical thoughts about:
    - being unskilled and inexperienced in conducting qualitative research
    - being an uncompassionate clinician
    - being impulsive.
- **Future worries; doubts about:**
  - Being skilled and experienced enough to submit a piece of qualitative research for publishing.
  - Being able to contain previous experiences, and remain open to participants' experiences.
  - Being able to submit thesis on time.

Experiential avoidance and cognitive fusion →
- Rumination about past: memories of working on an IPS, and becoming uncompassionate towards patients.
- Worrying about future: remaining an uncompassionate clinician; failing the course, being negatively viewed as an impulsive colleague.
- → **poor self-knowledge in present moment**

Experiential avoidance and cognitive fusion →
- **(Some) poor clarification of certain values, for example:** empathy, compassion, curiosity, valuing individuals' uniqueness, connectivity, open, non-judgemental, harmonious communication.
- **Rule-governed behaviours dominating:**
  - **Excessive pliance:** must always be 'perfect', 'model' student, constantly productive and high-achieving.
  - **Problematic augmenting:** reinforcing effects of values-based behaviours overshadowed by thoughts about being unskilled, inexperienced, uncompassionate, impulsive.

DISTANT
Poor self-knowledge, concepts of past and feared future dominate

PASSIVE
Poor clarity surrounding values, rule-governed behaviours

CLOSED
Experiential avoidance

CLOSED
Cognitive fusion

Psychological Inflexibility

PASSIVE
Lack of action, impulsive and/or avoidant behaviours

DISTANT
Attached to seeing self as a concept
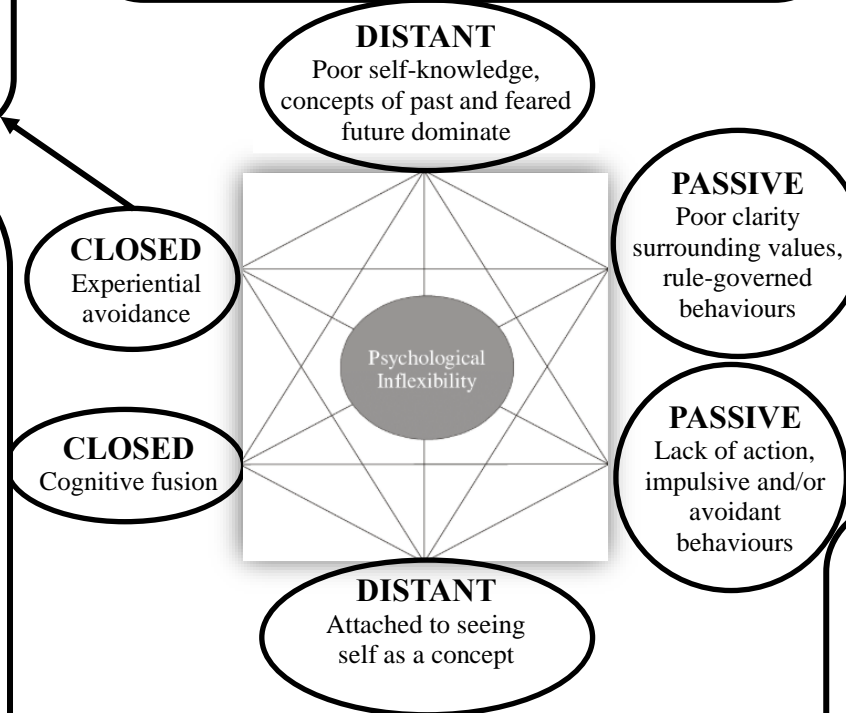
Fused with negative dominant (?) self-descriptions:
- Beliefs about being:
  - unskilled, inexperienced
  - an uncompassionate clinician
  - impulsive.

Persistent (?):
- **Avoidance and lack of action:** not persistent, due to being in touch with values the majority of the time.
- **Impulsivity:** emailing research team, expressing negative thoughts and feelings without pausing to think through implications; etc.

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Figure 3.1 shows that I had some psychological inflexibility during the empirical research. Labelled 'closed', preparing to begin the qualitative research (e.g. when participating in a 'bracketing interview') and communicating with my research tutors were situations associated with me becoming fused with (Harris, 2009) some challenging internal experiences (memories, feelings and thoughts, and worries). More specifically, when it came to planning the research, feelings of being overwhelmed and incompetence arose, alongside self-critical thoughts about being unskilled and inexperienced in qualitative methodologies. These thoughts and feelings linked to worries about the future, questioning whether I was skilled and experienced enough to submit a piece of qualitative research for publishing.

In addition, I experienced cognitive fusion to challenging memories, feelings, thoughts and worries that arose during a bracketing interview with one of my research tutors. During this, I felt sad recalling memories of working as a healthcare assistant support worker (HCASW) in an inpatient psychiatric service (IPS), similar to the role and workplace of the participants I would be interviewing for my empirical research. Specifically, recollections of gradually becoming less compassionate in my approach to inpatients because I found keeping "connected to the human side of you is emotionally exhausting". After the interview, I continued to ruminate about my seemingly diminished compassion. I began worrying that my experiences had resulted in me becoming an uncompassionate clinician and that I would not be able to return to my value of being a compassionate human being. I also began to worry whether I would be able to contain these experiences in order to remain open and impartial to participants' experiences. Lastly, I was fused to a mixture of confusion and exhaustion in response to an email exchange with my research tutors, which I interpreted as giving me conflicting feedback. These feelings soon turned into panic, worrying that I would not meet the research deadline.

Also labelled 'closed', experiential avoidance is commonly experienced in response to challenging internal experiences, such as these. I had already demonstrated considerable such avoidance, having consistently avoided thinking about unpleasant memories of working as an HCASW up until the bracketing interview. Driven by self-critical thoughts about my skills and experience in conducting qualitative research, I initially put off planning research. I avoided opening emails from my research tutors for a brief period, due to doubts that I would be able to submit my research on time if I received more conflicting feedback. However, cognitive fusion and experiential avoidance have, overall, been limited in their impact during the empirical research process due to some personal psychological flexibility, shown in Figure 3.2.

Figure 3.2

Hexaflex of psychological flexibility

Learn and practise mindfulness methods to:
- Decrease rumination about:
  - Memories of working on an IPS, and becoming uncompassionate towards patients.
  - Worries about: remaining an uncompassionate clinician; failing the course; being negatively viewed as an impulsive colleague.
- Increase awareness of present moment and direct experience.

Acceptance of:
- Challenging internal experiences.

Involving:
- Allow challenging internal experiences to be around, despite not wanting/liking them.
- Reduction of experiential avoidance strategies.
- Increase in values-based

Clarify values, specifically: care, compassion, curiosity, valuing individuals' uniqueness, connectivity, open, non-judgemental, harmonious communication.
Explore how values can inform goals and behaviours.

Detach from:
- Challenging internal experiences: feelings, thoughts, memories, future worries (see 'Hexaflex of inflexibility'; Figure 3.1).

Through: learning and practising cognitive de-fusion methods to see cognitions as mere subjective verbal constructs.
→ **As a by-product, increasing positive, contained internal experiences:**
- Feelings: curiosity, motivation, confidence, clarity, pleasant surprise, contentedness, compassion.
- Thoughts: about being in touch with values, and compassionate.

AWARE
In contact with present moment

OPEN
Acceptance

OPEN
Cognitive de-fusion

Psychological flexibility

ACTIVE
Values

ACTIVE
Committed action

AWARE
Seeing self as a context

Learn and practise mindfulness methods to:
- Increase awareness of negative dominant self-description:
  - Beliefs about being:
    - unskilled, inexperienced
    - an uncompassionate clinician
    - impulsive

Set values-based goals, centred on:
- Contacting each cohort of new staff at the IPS and interviewing two to three participants per month.
- Write-up: meeting specific deadlines, agreed with research team, for submitting drafts of empirical research sections.
- Pausing before sending emails, saving drafts and coming back to them to edit before sending, if

Labelled 'open', I have been able to learn and practise several cognitive de-fusion methods (e.g. 'leaves on a stream' exercise, hearing thoughts sung to the tune of 'Happy Birthday'; Harris, 2009) during clinical training, which have loosened my attachment to challenging internal experiences. As a result, I have come to see the challenging internal experiences I am subject to as mere subjective constructs. So, I can allow them to be present, despite not wanting or liking them, lessening the need for experiential avoidance and making more room for positive internal experiences.

As Figure 3.2 shows, positive internal experiences included feelings of empathy, compassion, curiosity, motivation, pleasant surprise, contentedness, clarity and confidence. Empathy arose when I thought about participants potentially having had similar unpleasant experiences of working on an IPS to me. This empathy, moving to a compassionate urge to help HCASWs, was the catalyst to curiosity around the exploration of their unique experiences. Pleasant surprise arose when interviewing participants, whose experiences of working on an IPS were different from and more varied than mine, and those that I disclosed during the bracketing interview. I also felt content at this, as it meant I had succeeded in managing my past experiences and memories to unbiasedly remain open to participants' experiences.

Lastly, throughout the research process, I felt a confident sense of clarity, associated to thoughts that I was conducting empirical research on a topic, and in line with an epistemology, that accord with my personal values of openness and valuing individuals' uniqueness. Therefore, I have been able to proceed with clarity and confidence in spite of challenging internal experiences.

However, moving on to the 'distant' components of psychological inflexibility (see Figure 3.1), a mixture of cognitive fusion and experiential avoidance can lead to individuals becoming 'distant'. This is due to internal worlds being dominated by past memories and future worries, and poor knowledge of the self in the present moment. Despite cognitive de-fusion methods, I have experienced periods of rumination and worrying. However, again, this has been counteracted by the corresponding area on the 'hexaflex of psychological flexibility' labelled 'aware' (Harris, 2009; Figure 3.2). Many years of practising meditation as a Buddhist have meant that I have remained in contact with my direct experience in the present moment, avoiding becoming embroiled in memories or worries. Becoming increasingly 'aware' through mindfulness skills, I have become accustomed to seeing myself as a context experiencing subjective negative self-descriptions (being unskilled, inexperienced, uncompassionate) that, occasionally, made me 'distant'.

Incorporating behaviours, I would not describe myself as 'passive' (see Figure 3.1); however, at times while conducting empirical research, I have shown poor clarity of values through doubting my values of compassion, connectivity and harmonious communication. As a lover of rules, I have been susceptible to rule-governed behaviours, dictated by excessive pliancy around consistently being a 'perfect', 'model' student, who is unfalteringly productive and high-achieving.

In turn, I have sometimes been diverted away from values-based behaviours. For instance, linking to 'passive' impulsivity, I sent an abrupt email to my research tutors in response to conflicting feedback from them. This was driven by not only excessive pliancy but also cognitive fusion (e.g. exhaustion and frustration), poor clarification of values around connectivity and harmonious communication, and problematic augmenting: the reinforcing effects of behaving in line with values overshadowed by negative self-descriptions of being unskilled and inexperienced. This only increased the challenging internal experiences I was fused with, adding an additional worry: that my behaviour could become impulsive when feeling exhausted and frustrated, and rumination about being negatively viewed as an impulsive colleague. Therefore, my likelihood of resorting to experiential avoidance through not checking for subsequent emails from my research tutors was increased.

In addition, problematic augmenting (specifically, the self-description of being uncompassionate) was also motivating my research interest for a brief period. I found myself seeking reassurance and normalisation through shared experience with participants, who I expected to have similar experiences to me, rather than the research being motivated by values of empathy, compassion, curiosity and valuing individuals' uniqueness.

Being 'passive' did not persist because I was in touch with strongly-held personal values. Generally, when something is incongruent with my values, challenging internal experiences arise, triggering reflexivity that often prompts behavioural change, reorienting towards my values. Regarding the empirical research process, I became increasingly 'active' (see Figure 3.2) by reclarifying my values, through imagining how I would like other people, peers and colleagues, to describe me at the end of training, and what I would like others to remember me for (similar to Harris's [2007] 80th birthday party exercise). This helped me reconnect with, for instance, values of empathy, compassion, openness, curiosity, valuing individuals' uniqueness, connectivity and harmonious communication, which started to dictate my behaviours more than excessive pliancy or problematic augmenting. As a result, I have been able to act in accordance with clarified values, in spite of any challenging internal experiences, depicted by the ACT matrix (Polk & Schoendorff, 2014; Figure 3.3).

Figure 3.3

ACT matrix

<div align="center">OUTSIDE ME</div>

3 What I (sometimes) do when I'm in control of unpleasant/unwanted thoughts, feelings and memories, causing movement away from who and/or what's important to me:

Avoid unpleasant past memories of working as an HCASW on an IPS.

Avoid planning research.

Send impulsive emails, avoid checking emails for responses.

Reassurance-seeking through seeking participants' collusion with my remembered experiences.

Being excessively pliant: constantly trying to be productive, and maximise my output to be perfect, 'model' student.

4 Things I could be doing (or am doing) to move towards who and/or what is important to me:

Reading about qualitative research.

Contacting each cohort of IPS HCASWs and interviewing two to three participants per month.

Write-up: meeting specific deadlines, agreed with research team, for submitting drafts of empirical research sections.

Pausing before sending emails, saving drafts and coming back to them to edit before sending, if necessary.

AWAY MOVES ←———————————→ **TOWARDS MOVES**

2 Unpleasant/unwanted thoughts, feelings and memories that (sometimes) stop me moving towards who and/or what is important to me:

Past memories of unpleasant experiences working as an HCASW in an IPS.

Present feelings of overwhelm, incompetence, anxiety, worry, confusion, exhaustion, panic.

Present self-critical thoughts

Future worries and doubts

1. Who and/or what is important (values) to me:

Empathy
Compassion
Curiosity
Valuing individuals' uniqueness
Connectivity
Openness
Non-judgemental
Harmonious communication

<div align="center">INSIDE ME</div>

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3.2 Evaluation

Through formulating reflections, some commonalities across them became clear, accurately encapsulated by the term 'contained versus uncontained'. Here, the former refers to my ability while conducting empirical research to, reservedly, manage challenging internal experiences as they arose, not allowing them to steer my behaviours but proceeding in line with my values. Conversely, the latter refers to my inability to effectively regulate challenging internal experiences as they arose, so that they steered my behaviours away from my values.

Drawing on relevant research to inform a reflexive evaluation, I will now discuss this further in relation to: (a) preparing to begin qualitative research as uncontained; (b) containment during data collection as a result of the bracketing interview; and (c) communication with research tutors as uncontained.

3.2.1 Preparing to begin qualitative research as uncontained

Beginning qualitative empirical research was an uncontained experience for me. Specifically, the challenging internal experiences, in the form of thoughts and self-descriptions, around being unskilled and inexperienced in qualitative research arising during the planning phases. This links to the argument that learners progress through four progressive stages (see Figure 3.4; Broadwell, 1969).

Figure 3.4

Stages of competence (Broadwell, 1969)
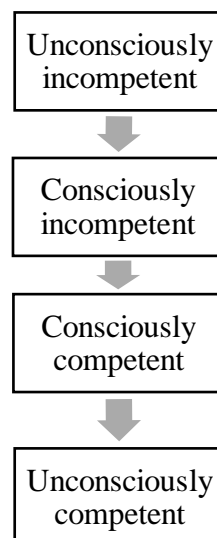
It seemed that becoming increasingly conscious of my incompetence as a qualitative researcher led to several uncontained challenging internal experiences, which caused avoidance through procrastination. Evidence shows that procrastination can be an effective short-term coping strategy although, in the long-term, it only maintains negative thoughts and feelings (Sirois & Pychyl, 2013). Going forwards in my CP career, I will need to respond to conscious incompetence in a more contained way, channelling it to positively motivate further learning in line with my values.

In addition, challenging thoughts and self-descriptions link to the 'imposter phenomenon' (Clance & Imes, 1978). This was originally identified in high-achieving, perfectionist females who viewed themselves as frauds, putting their achievements down to external variables, rather than taking the credit themselves. More recently, Parkman (2016) has highlighted the prevalence of the imposter phenomenon in higher education students and faculty members. Falling into the perfectionist, achievement-driven, student category, and having heard many seasoned CPs report this phenomenon, I think it is a challenging internal experience that I will become increasingly familiar with! Going forwards, when thoughts and self-descriptions around being an unskilled and inexperienced imposter arise, I will take a more contained response, using cognitive de-fusion and mindfulness exercises to detach from and accept them, returning to my direct experience.

There was also a lack of containment of challenging internal experiences that arose during and immediately after the bracketing interview. Unpleasant memories of experiences of working as an HCASW led to rumination and worrying about being an uncompassionate clinician. There is evidence to suggest that compassion fatigue (CF) is prevalent in health and social care professionals (Bhutani et al., 2012; Perry et al., 2011; Thomas, 2013). After the bracketing interview, I felt particularly worried because operating as a clinician without genuine compassion would be incongruent with my values, and it is living in line with personal values that leads to a full and enriching life (Harris, 2009). So, I found myself wanting reassurance and normalisation through shared experiences with other HCASWs, who I thought might also report CF. Evidence has shown shared experiences with similar others can provide reassurance and normalise experiences (Knox et al., 1997).

However, on reading more about CF, I discovered evidence that reassured me and normalised my experiences instead. This evidence reported that practitioners with higher levels of baseline empathy are more likely to experience CF (Turgoose & Maddox, 2017). I felt content that any CF I experienced when I was an HCASW was perhaps due to being an empathic person. Mindfulness is said to be a protective factor against CF (Turgoose &

Maddox, 2017), my skills in which will help me to be a consistently compassionate clinician in the future. In this way, my worries around CF were contained, as I was able to detach from and accept them to reconnect with, and reorientate towards, my values of empathy, compassion, openness, curiosity and valuing individuals' uniqueness as the motivation for empirical research.

3.2.2 Containment during data collection as a result of bracketing interview

The bracketing interview, although quite an uncontained experience both during and immediately after, was invaluable when it came to interviewing participants. It was the catalyst to reflection around researcher bias in qualitative research, highlighting to me that I needed to make sense of and process these memories, and resultant assumptions and expectations, to be an unbiased researcher. This accords with the argument that qualitative researchers should reflexively consider their position, perspective, biases and preconceptions in relation to their participants (Chinn, 2007; Råheim et al., 2016).

More specifically, as explained in Chapter 2, researchers can be in 'insider' or 'outsider' positions (Dwyer & Buckle, 2009; Ross, 2017). Having worked in a similar IPS role in the past, I initially presumed I was simply an 'insider'. However, this dichotomy oversimplifies positions: as Asselin (2003) argues, even though a researcher might be a member of the same culture being studied, they might not be part of the same subculture. As it happened, I was only a 'partial insider', as opposed to a 'total insider' (Chavez, 2008): I might have been part of an IPS HCASW staff culture, but I was not part of the same subculture as my participants. Having reflexive knowledge of this position helped me to remain unbiasedly open to the experiences of participants and reorientate towards being open and curious about their unique experiences.

Some academics have argued that researcher self-disclosure around 'insider' positions and shared experiences during an interview can encourage participants to elaborate and be more open (Reinharz & Chase, 2003), especially with difficult subjects (Jourard, 1971). As a result of discussing this during the bracketing interview, I told all participants that I had experience of working as an HCASW on an IPS. However, some academics argue that the outcome of researcher self-disclosure can depend on participants' interpretation (Abell et al., 2006). Therefore, my disclosure could have given them the impression that I did not need them to elaborate in response to questions as much as I would have liked (Abell et al., 2006). These different interpretations across participants could explain why interviews differed in the breadth and depth.

As a result of considering my position in relation to participants, data collection was a far more contained experience, and I was able to remain unbiased and open to my participants' unique experiences. Of course, when conducting future qualitative research, I will remember the value of bracketing beforehand. It was this containment that allowed the participants to express their unique experiences.

3.2.3 Uncontained in communications with research tutors

An uncontained experience for me was receiving conflicting feedback from my research tutors, and then impulsively responding to this out of exhaustion and frustration, compromising my values of connectivity and harmonious speech. Reflecting on this, I fluctuated between an internal and external locus of control for this uncontained experience. That is, respectively, between thinking (a) it was my dysregulated emotions that led to the lack of containment and (b) that my dysregulated emotions were, actually, the result of not feeling 'held', or contained, by my research team. In all likelihood, it was probably a mixture of both. Whatever the case, in line with the argument that challenging experiences can be positive learning experiences (Bower, 1992), I now realise that, when I find it difficult to contain certain thoughts and emotions, it is helpful to pause and process these challenging internal experiences before responding. This is a technique we, as clinicians, commonly teach to patients in, for instance, dialectical behaviour therapy. Indeed, it is recommended that practitioners try out the therapeutic techniques on themselves, and then reflect, in a process known as self-practice/self-reflection (Bennett-Levy et al., 2003). This resulted in me altering the way I communicated with my research tutors, expressing my thoughts and feelings in a premeditated manner, contributing to constructive, harmonious and contained communication.

3.4 Conclusion

I am now fully aware of the value of reflection and being a reflexive scientist–practitioner, experiencing first-hand how this encourages practice that is effective, skilled and ethical (Furr & Carroll, 2003). With strong and increasingly clear personal values, I can be quietly confident that I am an open, aware and active practitioner. As such, I can have challenging internal experiences, while confidently proceeding to move towards living a full and enriching personal and professional life.

I remain open to using new and innovative ways of extending my reflections through, for instance, applying clinical approaches. As a result of applying ACT here, I will retain

self-awareness of my tendency to become fused to certain cognitions, feelings and memories. And, I will make efforts to hold these experiences lightly, remain present and let go of rule-governed ways of behaving. For this, I will have to make repeated efforts to clarify and connect with my values, which could shift and change over time, to ensure that my research and clinical practice are firmly rooted in them. In addition, I will remain aware of challenging the internal experiences arising and the ability to respond to them in a containing way that accords with these values.

Looking to future research, I think I will proceed with more confidence in qualitative approaches. Specifically, I would like to explore the experiences of people who have been in caring roles (including family, carers and professionals) for longer periods of time, regarding how they have experienced the "personal and professional pull" over time, fluctuations in empathy, and CF, and how this relates to mindfulness. For this, it will be important for me to be supervised by, or work alongside, research tutors, or a research team, who I will show respect as being more competent and experienced than me in the field of qualitative research. This will aid my continued awareness, reflection and learning around not only qualitative processes but also personal and epistemological reflexivity, given the past experiences, positions, expectations and biases I carry with me.

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Author instructions for submission to the to the Journal of Eating Disorders

Review

Criteria

Reviews are summaries of recent insights in specific research areas within the scope of *Journal of Eating Disorders*.

Key aims of reviews are to provide systematic and substantial coverage of mature subjects, evaluations of progress in specified areas, and/or critical assessments of emerging technologies.

Plain English summary

All articles in *Journal of Eating Disorders* require a **Plain English summary** of between 100 and 200 words, in addition to the Abstract. This should be a summary of the article written in language suitable for people with lived experience of illness and the wider public to easily understand. It should not contain technical terminology or complicated statistics. It should convey the key messages of your paper.

Please include this within the main body of your manuscript file. Please do not include the plain English summary as part of the official scientific abstract that is requested separately by the journal submission system. The plain English summary should be inserted immediately after the official scientific abstract within the manuscript file under the heading "Plain English summary".

By adding a plain English summary, we hope to broaden the reach of the article and bring it to the attention of a more general audience. Researchers are trained to be highly focused, specific, and conservative with extrapolation and speculation. These attributes are useful for scientific publications, but not for wider public understanding. Many non-scientists have difficulty understanding technical terms and jargon, and the public requires more context-setting by way of introduction and more help drawing a conclusion.

The following resources provide further information: INVOLVE Plain English summaries resource; The Plain English Campaign guide on medical writing; Cochrane Library.

Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section.

Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page should:

- present a title that includes, if appropriate, the study design e.g.:

- o "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"
- o or for non-clinical or non-research studies: a description of what the article reports
- • list the full names and institutional addresses for all authors
  - o if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "Acknowledgements" section in accordance with the instructions below
- • indicate the corresponding author

Abstract

The Abstract should not exceed 350 words and should be structured with a background, main body of the abstract and short conclusion. Please minimize the use of abbreviations and do not cite references in the abstract.

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should explain the background to the article, its aims, a summary of a search of the existing literature and the issue under discussion.

Main text

This should contain the body of the article, and may also be broken into subsections with short, informative headings.

Conclusions

This should state clearly the main conclusions and include an explanation of their relevance or importance to the field.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations should be provided.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

Appendix B

Quality assessment criteria and researcher's scores

CASP screening and quality assessment criteria	Albertsen et al. (2019)	Hedlund & Landgren (2017)	Holmes et al. (2017)	Larsson et al. (2018)	Morgan et al. (2014)	Owen & Fullerton (1995)	Padfield et al. (2017)	Padrao & Coibra (2011)	Sparrow & Tchanturia (2016)	Tchanturia et al. (2014)	Zuchova et al. (2013)
1. Clear statement of research aims	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)
2. Appropriate qualitative methodology	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)
3. Research design appropriate to address research aims	1	1	1	1	1	.5	.5	1	1	1	1
4. Recruitment strategy appropriate to research aims	1	.5	1	1	1	.5	.5	1	1	1	1
5. Data collected in way that addresses research issue	1	.5	1	1	.5	.5	.5	.5	1	.5	1

|											
6. Relationship between researcher and participants adequately considered	1	.5	.5	0	0	.5	.5	0	0	0	0
7. Ethical issues taken into consideration	.5	.5	1	.5	0	0	1	.5	0	.5	0
8. Data analysis sufficiently rigorous	1	1	1	.5	.5	1	0	0	.5	0	0
9. Clear statement of findings	1	1	1	1	.5	.5	1	1	1	1	.5
10. Research valuable	.5	1	1	1	1	.5	1	.5	.5	.5	.5
TOTAL SCORE	9 High quality	8 Mod. quality	9.5 High quality	7.5 Mod. quality	6.5 Low quality	6 Low quality	7 Low quality	6.5 Low quality	7 Low quality	6.5 Low quality	6 Low quality

Quality assessment criteria and reliability checker's scores

CASP screening and quality assessment criteria	Albertsen et al. (2019)	Hedlund & Landgren (2017)	Holmes et al. (2017)	Larsson et al. (2018)	Morgan et al. (2014)	Owen & Fullerton (1995)	Padfield et al. (2017)	Padrao & Coibra (2011)	Sparrow & Tchanturia (2016)	Tchanturia et al. (2014)	Zuchova et al. (2013)
1. Clear statement of research aims	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)
2. Appropriate qualitative methodology	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)	1 (Yes)
3. Research design appropriate to address research aims	1	1	1	.5	1	.5	.5	1	1	1	1
4. Recruitment strategy appropriate to research aims	1	.5	1	.5	.5	.5	.5	1	1	1	1
5. Data collected in way that addresses research issue	1	.5	1	1	.5	.5	.5	.5	1	.5	1
6. Relationship between researcher and	.5	.5	.5	0	0	.5	1	0	0	0	0

participants adequately considered											
7. Ethical issues taken into consideration	.5	.5	1	.5	.5	0	1	0	0	0	0
8. Data analysis sufficiently rigorous	1	1	1	.5	.5	.5	.5	0	.5	0	0
9. Clear statement of findings	1	1	1	1	.5	.5	1	1	1	.5	.5
10. Research valuable	.5	1	1	1	.5	.5	1	.5	1	.5	.5
TOTAL SCORE	8.5 Moderate quality	8 Mod. quality	9.5 High quality	7 Low quality	6 Low quality	5.5 Low quality	8 Mod. quality	6 Low quality	7.5 Mod. quality	5.5 Low quality	6 Low quality

Appendix D

Hierarchical tree diagram of descriptive themes
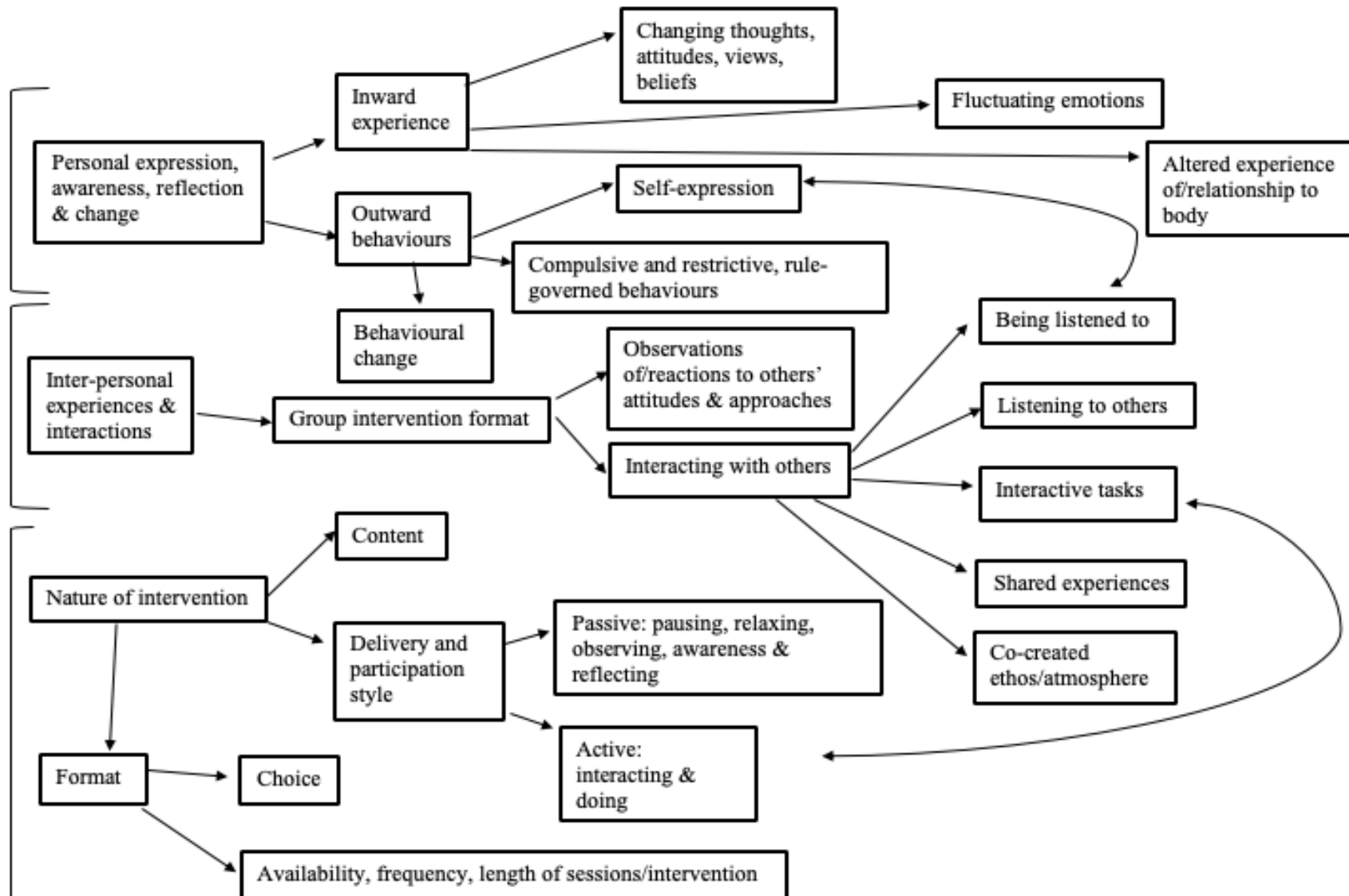
Author instructions for submission to the to the Journal of Psychiatric and Mental Health Nursing

i. Original Research

Word limit: 5,000 words maximum, excluding abstract and references.
Abstract: 200 words maximum; must be structured under the sub-headings: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice.

Accessible Summary: 250 words maximum; the purpose is to make research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. The Accessible Summary should be written in straightforward language, structured under the following sub-headings, with 1-2 bullet points under each: What is known on the subject; What the paper adds to existing knowledge and What are the implications for practice.

Description: The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing.

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that-in 100 maximum, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.
Reporting Checklist: Required - see **Section 5**.

PREPARING YOUR SUBMISSION

Cover Letters
Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures; COI form.

Title Page:

The title page should contain:

  i.   A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips).
 ii.   A short running title of less than 40 characters
iii.   The full names of the authors
 iv.   The authors' institutional affiliations at which the work was carried out
  v.   Corresponding author's contact email address and telephone number
 vi.   Acknowledgements.
vii.   Ethical statements.
        The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Authorship
For details on eligibility for author listing, please refer to the journal's Authorship policy outlined in

the Editorial Policies and Ethical Considerations section.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File

The main text file should be presented in the following order:

    i.   Title, abstract and key words;
    ii.   Main text;
    iii.   References;
    iv.   Tables (each table complete with title and footnotes);
    v.   Figure legends;
    vi.   Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

Style Points

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

Abstract

Abstracts and keywords are required for some manuscript types. For details on manuscript types that require abstracts and/or keywords, as well as how to prepare them, please refer to the 'Manuscript Types and Criteria' section.

Keywords

Please provide up to seven keywords When selecting keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **https://www.nlm.nih.gov/mesh/**.

References

For details on references please refer to the 'Manuscript Types and Criteria' section.

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition).

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that

order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although we encourage authors to send us the highest-quality figures possible, for peer-review purposes we are happy to accept a wide variety of formats, sizes, and resolutions.
Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.
Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Guidelines for Cover Submissions

If you would like to send suggestions for artwork related to your manuscript to be considered to appear on the cover of the journal, please **follow these general guidelines**.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information

Supporting information is information that is not essential to the article but that provides greater depth and background. It is hosted online, and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc. **Click here** for Wiley's FAQs on supporting information. Note, if data, scripts or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style:

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Spellings:** should conform to those used in the Concise Oxford Dictionary.
- **Footnotes:** should be avoided.

Certificate of Ethical Approval

Applicant:

Sophie Clifton

Project Title:

What are healthcare assistants' and support workers' experiences of responding to their first few incidences of deliberate self-harm on acute psychiatric in-patient wards?

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

12 March 2019

Project Reference Number:

P78337

Semi-structured interview guide

1. Tell me a bit about yourself and your role working here

Part 1: Before working on IPS
2. Tell me about your experiences of deliberate self-harm prior to working here.

Prompts: views, personal life, impact, training

Part 2: During working on IPS
3. Tell me about your experiences of hearing new colleagues talking about responding to deliberate self-harm when you first started working here.

Prompts: what happened, what heard, what stuck in mind, reactions (thoughts, physiologically, emotionally), responses (coping strategies)
4. Tell me about your first experience of responding to deliberate self-harm working here.

Prompts: who involved, what happened, reactions (thoughts, physiologically, emotionally), responses (coping strategies)
5. What was your experience immediately after this incident?

Prompts: what noticed, reactions (thoughts, physiologically, emotionally), responses (coping strategies)
6. What was your experience after you finished your shift that day?

Prompts: what noticed, reactions (thoughts, physiologically, emotionally), responses (coping strategies)
7. What was it like going in for your next shift after this first incident?

Prompts: reactions (thoughts, physiologically, emotionally), responses (coping strategies)

8. Was your experience of responding to any subsequent incidences different to the experience of responding to the first incident?

Prompts: what noticed, reactions (thoughts, physiologically, emotionally), responses (coping strategies)
Generic prompts throughout:
    "Can you give me an example?"
    "Can you tell me a bit more about that?"
    "What was that like for you?"
    "How was that?"
    "Why was that?"
    "What did you think about that?"
    "How did you feel about that?"
    "What did it feel like?"
    "How did that impact you?"
    "How did you cope with that?"
    "What did that mean to you?"

Participant information sheet

You are being invited to take part in research on the experiences of specific healthcare staff, responding to their first few incidences of deliberate self-harm on acute psychiatric in-patient wards. Sophie Clifton (Trainee Clinical Psychologist) at Coventry University is leading this research. Before you decide to take part it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of this study is to explore the experiences of healthcare assistants and/or support workers responding to their first few incidences of patient deliberate self-harm whilst working 'on the floor' of an acute psychiatric in-patient ward.

Why could I be chosen to take part?
You are invited to participate in this study if:

- You are either a support worker or healthcare assistant, not qualified to one of the following levels in or outside the UK: doctor, psychiatrist, clinical/counselling psychologist, general nurse, psychiatric nurse, occupational therapist, or a student/trainee of the above.
- You currently work directly with patients on an acute psychiatric in-patient ward.
- You currently respond directly to patients who deliberately self-harm.
- You have worked on an acute psychiatric in-patient ward, responding to patients who deliberately self-harm for a total of four months or less, either on this ward, or whilst working on any other ward in the past.
- You are fluent in English.

What are the benefits of taking part?
By sharing your experiences with us, you will be helping Sophie Clifton and Coventry University to better understand the experiences of specific healthcare staff, responding to their first few incidences of deliberate self-harm on acute psychiatric in-patient wards. In turn, this could help inform training and support for other staff similar to you, developing and improving practice.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's formal research ethics procedure. There are no significant risks associated with participation. However, there is a slight risk that some of the areas covered in the interview might cause you some distress. Should this be the case, the interview will be paused and we can review whether you would like to continue. You have the right to withdraw at any time during the interview. Additionally, a list of resources for support post-interview will be available for you to take away with you, should you wish to.

Do I have to take part?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw

from the study at a later date. You are free to withdraw your information from the project data, without giving a reason, at any time within four calendar weeks of being interviewed. You should note that your data may be used in the production of formal research outputs (e.g. journal studies, conference papers, theses and reports) prior to this and, so, you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (contact details are provided below).

Please also contact the Research Support Office (email: hls.rso@coventry.ac.uk; tel: +44(0)2477653805) so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?
You will be asked a number of questions regarding your understanding and views of deliberate self-harm, your experiences responding to incidences of patients deliberately self-harming, and what this means for you. The interview will take place in a safe environment at a time that is convenient to you. Ideally, we would like to audio record your responses (and will require your consent for this), so the location should be in a fairly quiet area. The interview should take around one hour to complete.

You must not disclose the names of patients during the interview. This is to help prevent them, and the service, being recognised. Patients have also not given their permission to be named in the study. If you accidently name a patient, their name will not be included in the transcript of the interview.

During the interview, if you raise any significant concerns surrounding the physical and/or emotional wellbeing of yourself or any other individual, staff or patients, then it could be that, due to my duty of care to you, other staff and patients, I need to pass my concerns on to the Safeguarding Lead/s employed by Cygnet Health Care. This might then be investigated to ensure the safety and support of all individuals.

Data Protection and Confidentiality
Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept strictly confidential. Your data will be fully anonymised in our records, referred to by a unique participant number, rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored on a password-protected memory stick, stored in a locked filing cabinet at Coventry University.

All paper records, including your transcribed interviews and consent information, will be stored in locked filing cabinets at Coventry University, although your transcribed interviews and consent information will be kept separately to minimise the risk of you being identified in the event of a data breach. The lead researcher will take responsibility for data destruction. All audio recordings will be destroyed immediately after transcription; transcriptions will be destroyed at the end of September 2023.

Data Protection Rights
Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with

the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer – enquiry.ipu@coventry.ac.uk

What will happen with the results of this study?
The results of this study may be summarised in published studies, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name.

Making a complaint
If you are unhappy with any aspect of this research, please first contact the lead researcher, Sophie Clifton (clifton9@uni.coventry.ac.uk). If you still have concerns and wish to make a formal complaint, please write to Jo Kurchaska (jo.kucharska@coventry.ac.uk) or
Sarah Simmonds (sarah.simmonds@coventry.ac.uk).

Sophie Clifton
Trainee Clinical Psychologist
Coventry University
Coventry CV1 5FB
Email: clifton9@uni.coventry.ac.uk

In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

Participant No.

Coventry University

What are staff's experiences of responding to their first few incidences of deliberate self-harm on acute psychiatric in-patient wards?

You are invited to take part in this research study for the purpose of exploring the experiences of healthcare staff, responding to their first few incidences of deliberate self-harm on acute psychiatric in-patient wards.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

All paper records, including your transcribed interviews and consent information, will be stored in locked filing cabinets at Coventry University, although your transcribed interviews and consent information will be kept separately to minimise the risk of you being identified in the event of a data breach.

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions	YES	NO
2	I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office (email: hls.rso@coventry.ac.uk; tel: +44(0)2477653805) any time within four calendar weeks of my interview	YES	NO
3	I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study	YES	NO
4	I understand that all the information I provide will be held securely and treated confidentially	YES	NO
5	I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs	YES	NO

6	I am happy for the interview to be <u>audio recorded</u>	YES	NO
7	I agree to take part in the above study	YES	NO

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	Date	Signature
Researcher	Date	Signature

Appendix J

Participant demographics form

How old are you?	
With what gender do you identify?	☐ Male ☐ Female ☐ Non-binary
What is your ethnic group?	**White** ☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Any other White background, please describe _____ **Mixed/Multiple ethnic groups** ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other Mixed/Multiple ethnic background, please describe _____ **Asian/Asian British** ☐ Indian ☐ Pakistani

	☐ Bangladeshi ☐ Chinese ☐ Any other Asian background, please describe _____ **Black/ African/Caribbean/Black British** ☐ African ☐ Caribbean ☐ Any other Black/African/Caribbean background, please describe _____ **Other ethnic group** ☐ Arab ☐ Any other ethnic group, please describe _____
What is your job title?	
Do you work here the equivalent of full-time (37.5 hours or more per week) or part-time (less than 37.5 hours per week) hours?	☐ Full-time ☐ Part-time
Are you Agency or Bank staff, or neither?	☐ Agency ☐ Bank ☐ Neither – employed directly by hospital
How long have you worked on this acute	

psychiatric in-patient ward?	
Do you work on any _other_ acute psychiatric in-patient wards at the moment?	☐ Yes ☐ No If yes, how long have you worked on this acute psychiatric in-patient ward?
Have you worked on any _other_ acute psychiatric in-patient wards in the past?	☐ Yes ☐ No If yes, how long did you work on this acute psychiatric in-patient ward?
In total, when working on wards, how many incidences of deliberate self-harm or suicide attempts/completions by patients have you responded to directly?	
Have you had any training in deliberate self-harm or suicide?	☐ Yes ☐ No
Are you trained in restraining patients?	☐ Yes ☐ No

Dear Participant,

Firstly, I would like to thank you for taking part in this research study. Each contribution is highly valued – without your involvement this research would not be able to take place.

What has happened?

You have just taken part in an interview with Sophie Clifton, Trainee Clinical Psychologist, for the purpose of research. The research is looking to understand the experiences of staff responding to their first few incidences of deliberate self-harm and/or suicide attempts/completion whilst working on acute psychiatric in-patient wards. You spoke to Sophie about your own personal experiences of this. You also filled in a brief questionnaire collecting demographic details, such as your age and occupation details.

What will happen next?

There is nothing further you need to do. The interview will be transcribed and analysed by the researcher and written into a report. If you decide you would like to withdraw your consent to be included in this research, you can contact the research team at any time. You should note that your data may be used in the production of formal research outputs (e.g. journal studies, conference papers, theses and reports) prior to this and, so, you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study.

If you would like a summary of the research findings please inform Sophie of this. On completion, the research report in its entirety will be accessible by you through Coventry University.

We have spoken about some sensitive experiences and this can be upsetting. If you would like further support, please utilise some of the contact details below. Should you wish to make a complaint, or for more information about this research, please refer to the Participant Information Sheet.

Many thanks,

Sophie Clifton
Trainee Clinical Psychologist, Coventry University

Support contact details:

- Your GP
- Your line manager/supervisor
- Employee Assistance Helpline:
  Freephone telephone number: 0800 328 1437
  Website: employeeassistance.org.uk
- Samaritans:
  Freephone telephone number: 116 123
  Email: jo@samaritans.org
  Website: www.samaritans.org
- Improving Access to Psychological Therapies (IAPT) service:
  Self-referral telephone number for psychological assessment & therapy: 024 7667 1090

299   by myself. | wanted to learn everything that I could. So yes, at the time you just kind

300   of push that to the back of your head I guess and try and take in even more

301   information.

302   INT: Yes, sure.

303   P1: But yes I think there were points in the day where I could go into the office and

304   staff would show me things then I would get the chance to ask them other questions

305   or sort of get them to talk through some stuff with me. So yes there were points

306   throughout the day but not necessarily immediately after something happened, yes.

307   INT: Sure, okay. So if we go back to after the first incident, erm, yes. I was just

308   wondering what was your experience after you had finished your shift that day.

309   P1: Erm, after I finished my shift, erm. I felt alright actually at the end of the shift,

310   erm. Overall the day was quite, I don't think pleasant, but it wasn't a horrendous |

311   shift and I felt, I did feel overwhelmed but that was just because I was trying to

312   remember so many people's names and things like that. Erm, so I was tired at the

313   end but I didn't feel really that down. I remember getting home and talking about it

314   all with my family.|

315   INT: Yes, okay

316   P1: Because they asked about it and obviously those incidents came up which I did

317   say yes it is really sad and it does make you just empathise, you try and empathise a

318   little bit. Erm, yes I didn't feel too bad at the end of it, it was more I was interested to

319   start my next one and see what else there was and what I could learn. I could

320   remember certain things but I knew there were bits I couldn't remember so I was

321   trying to learn it all. |

322   INT: So when you say you remember certain bits you mean, sort of certain bits of

323   information about different patients, their names and things like that .

Sophie Ann Clifton
Need to be in communal areas to learn everything

Emphasis on learning and experiencing directly while on the ward floor, not in office or a training room

Coping secondary to learning, taking in information

Limited capacity in head – taking in information Vs coping

Sophie Ann Clifton
Office as a place for processing information

Difference between communal areas and office area – communal is for taking in information, office is for reflecting, processing information

Sophie Ann Clifton
Not able to process events or cope straight away

No time for coping, has to be delayed until later

Sophie Ann Clifton
'pleasant' and 'horrendous' as opposites

Wasn't one or the other, somewhere in-between

Sophie Ann Clifton
Overwhelmed

Overwhelm caused by amount of information have to learn, amount of people

Tired

'not down' = as if I would or someone would expect that?

Sophie Ann Clifton
Talking to others as a coping strategy

External others as coping strategy

Sophie Ann Clifton
Cognitive empathy

Empathy as effortful 'try'

Sophie Ann Clifton
'didn't feel too bad' but not good either

No positive emotions

Sophie Ann Clifton
Interested, curious

Motivated to learn. Volume of information not off-putting, just need time

Sophie Ann Clifton
Learning as effortful and time-consuming

Working table of emerging themes, example excerpts and line numbers

Emergent themes	
CONTROL ON THE IPS	
PATIENTS AS CONTROLLING	
Patients as in control of DSSH	"She was mentioned a lot to the new people …'as a new person, she's going to look for you as weak blood … and she'll be ready … because she's chosen you as a victim.'" (George; 478–487)
Patients as in control of incidences, how escalate, what response (verbal or physical)	
Patients as in control of staff emotions, physiological reactions	
Patients as controlling what is talked about in office	"It sounded like the patients are out to get you and it's almost a prison setting where they will watch you watching them and, when you blink, they will do something … they're very scheming, and one will distract you while someone else does something." (George; 325–329)
Patients as encroaching on office	
PATIENTS AS CONTROLLED	
Patients as childlike	
Patients as being restricted and permitted	
Patients as like animals	
	"When you hear the history that has happened you always think, I felt like, 'Oh, I can see that child in them who should have been helped long ago.'" (Susann; 310–313)
	"If you break promises then I'm going to do this … trying to prove a point kind of way … it was a definite deliberate act, an act of defiance." (Elliot; 759–771)
RESPONSIBILITY/ACCOUNTABILITY ON THE IPS	
PERSONAL RESPONSIBILITY/ ACCOUNTABILITY FOR PATIENT SAFETY	
Being alone with patient increases sense of responsibility	"You don't know … the right things to say as the right thing to say to someone could be completely wrong for someone else" (Daisy; 430–432).
Responsibility for patients' safety as scary	
Responsibility for patients is not something wanted	
Being forced into a position of responsibility with patients	"If my reaction's not adequate there is somebody literally stood right next to me who knows exactly what they're doing. But, when I'm on my own I'm going to be responsible for the first response." (Jack; 551–555)
Pushed	
Responsibility as going wrong	
Readiness for responsibility	
SHARED STAFF TEAM RESPONSIBILITY/ACCOUNTABILITY FOR PATIENT SAFETY	
Shadowing other staff as shared responsibility	"It really scares everybody because then you get on the ward and you don't want to talk to anyone because you're just afraid you'll say something and they'll just self-harm. Because all you've been told is … bad things happen." (George; 534–538).
Shared responsibility as not scary	
PATIENTS AS RESPONSIBLE FOR THEMSELVES	
Patients as choosing to DSSH	"When you hear the history that has happened you always think, I felt like, 'Oh, I can see that child in them who should have been helped long ago'." (Susann; 310–313)
PATIENTS AS NOT REPONSIBLE FOR THEMSELVES	
Patients as childlike	
INTERRELATEDNESS AND CONNECTIVITY ON THE IPS	

PATIENTS AND STAFF AS SIMILAR, HUMAN
BEINGS
Patients and staff as needing coping mechanisms
Patients and staff as distressed
Patients and staff as connecting as human beings
STAFF–STAFF RELATIONSHIPS/RAPPORT
OTHER STAFF AS SIMILAR
Shared experience with other staff as being
inexperienced
OTHER STAFF AS DISSIMILAR
Other staff as rescuers
Other staff as having knowledge, experience and
expertise
Other staff as experts
STAFF TEAM ETHOS

"The human touch, the compassion thing … you shouldn't
need to know how to be a human being to somebody else."
(George: 1910–1911)

"You know I've got to have that connection with them
otherwise you're not going to be able to help them … if
you've got that good rapport with people … have a
chat … de-escalate stuff before it hits that level … as
opposed to a stand back, cold professional." (Elliot: 473–
491)

"They'll just … ask me if I'm all right, if I can cope, things
like that … they just reassure me." (Ann; 735–741)

"Because, if I was a bystander again, like I was pre-
restraint training, I wouldn't have been able to… feel that
familial bond."
(George; 1572–1574)

REAL LIFE versus IPS LIFE
IPS AS HORROR FILM, WAR OR DISASTER
ZONE
REAL LIFE VERSUS WORK
Distancing real life from work

"You know, some things you think, 'Oh it's awful, why
would you do that?' … but you're meant to have that
reaction, I guess. The only way I can properly prepare
myself for it is thinking it's going to be like a horror film."
(Ellie; 497–503)

Appendix N

Visual mapping of emergent themes, convergences and divergences
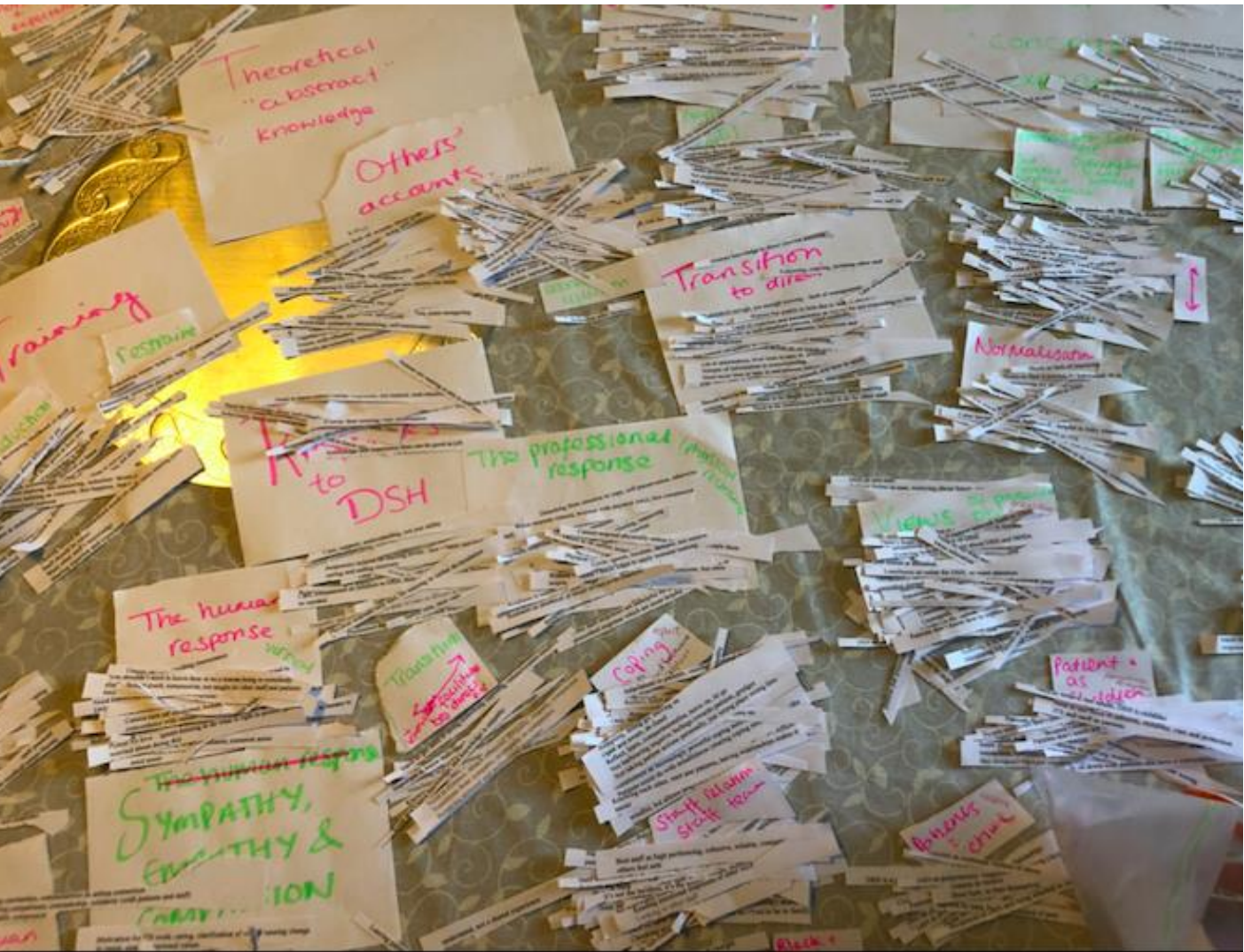
Personal cognitions bracketed during bracketing interview

Type of personal cognition bracketed (memory/assumption/expectation/belief)	Content of cognition bracketed during bracketing interview
Personal memory	Feelings of dread, aversion and fear associated with going in to work, questioning whether want to continue in role, but reassuring self that the role is only a "temporary means to an end".
Assumption	Staff across settings have feelings of dread, aversion and fear associated with working in inpatient psychiatric service wards.
Resultant expectation	HCASWs will report feelings of dread, aversion and fear associated with their role, causing them to question whether they want to remain in the role, unless it is only a "temporary means to an end".
Personal memory	Having no personal experience of deliberate self-harm, being shocked by the extent of deliberate self-harm and how normal it seemed to others.
Assumption	Staff across settings have little personal experience of deliberate self-harm in their backgrounds and, therefore, will be as shocked as I was.
Resultant expectation	HCASWs will report being shocked by the extent of deliberate self-harm and how normal it seems to others.
Personal memory	Decreased feelings of anxiety before (a) being restraint trained and (b) being responsible for one-to-one patient observations, due to decreased responsibility/accountability and being exempt from physically responding to deliberate self-harm.
Resultant expectation	HCASWs (a) not yet restraint trained and/or (b) not yet responsible for one-to-one patient observations will report decreased feelings of anxiety, compared with HCASWs who are restraint trained and responsible for one-to-one patient observations.
Personal memory	Feelings of dread in response to the prospect of physically restraining patients, really sad after restraining patients due to it being contrary to personal values of compassion.

Assumption	Staff across settings have feelings of dread and sadness related to physically restraining patients, due to having the same values, such as compassion.
Resultant expectation	HCASWs will report dreading physical restraints, with subsequent sadness due to it contradicting personal values, such as compassion.
Personal memory	Feelings of confidence and reduced anxiety once have been involved in one or two successful physical restraints.
Resultant expectation	HCASWs will report feeling more confident and less anxious once they have been involved in one or two successful physical restraints.
Memory of personal experience	Inpatient psychiatric service wards as unpredictable, which generated constant state of physiological arousal and fear of the unknown, operating in "threat" mode, making recollection of specific events difficult.
Resultant expectation	HCASWs will speak about the unpredictable nature of wards, generating constant state of physiological arousal and fear of the unknown, operating in "threat" mode, which will make recollecting specific incidences during interview difficult.
Personal memory	Becoming desensitised to seeing deliberate self-harm and resultant injuries, becoming increasingly "cold" to avoid emotional exhaustion.
Resultant expectation	HCASWs will report becoming increasingly desensitised to seeing deliberate self-harm and resultant injuries, becoming increasingly "cold" to avoid emotional exhaustion.
Assumption (black and white)	Healthcare is either humanistic *or* professional, with no middle ground.
Resultant expectation	HCASWs will report that the care provided on the wards is either humanistic *or* professional, with no middle ground.
Personal memory	Easier to verbally de-escalate deliberate self-harm incidences when had personal knowledge and understanding of individual patients, leading to decreased feelings of anxiety and increased confidence.
Assumption	Having personal knowledge and understanding of individual patients enables verbal de-escalation of deliberate self-harm across settings.

Resultant expectation	HCASWs will report it being easier to verbally de-escalate deliberate self-harm incidences when have personal knowledge and understanding of individual patients, leading to decreased feelings of anxiety and increased confidence.
Personal memory	No debriefs after deliberate self-harm incidences and lack of supervision due to time pressures.
Assumption	Other inpatient psychiatric service wards do not have time to debrief staff after incidences and supervision is rare.
Resultant expectation	HCASWs will report lack of debriefs after deliberate self-harm incidences and supervision, due to time pressures.