

THE USE OF REPERTORY GRIDS TO EXPLORE NURSING STAFFS'
CONSTRUAL OF ADULT SERVICE USERS ADMITTED TO A PSYCHIATRIC
INPATIENT WARD

A thesis submitted to the University of Manchester for the degree of
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Thesis Abstract

The Use of Repertory Grids to Explore Nursing Staffs' Construal of Adult Service Users Admitted to a Psychiatric Inpatient Ward

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Acute inpatient mental health nursing staff provide mental health care for individuals when they are most vulnerable and unwell. The therapeutic relationship can facilitate positive changes and recovery for individuals. Therefore, understanding nursing staff's attitudes is paramount. In this thesis, the attitudes of nursing staff towards those experiencing mental health difficulties was explored.

In the systematic review, the attitudes of European nursing staff supporting those experiencing severe mental health difficulties were synthesised and evaluated. A total of 14 cross-sectional studies met the inclusion criteria. The review identified that the role of personal experiences of mental health difficulties through friends or family members was shown to elicit more positive attitudes. Overall attitudes amongst nursing staff were varied, and factors that influenced these attitudes were less clear and consistent. The limitation of using cross-sectional questionnaires to explore attitudes was also discussed. Moreover, recommendations regarding further research priorities as well as clinical implications were identified.

Nursing staff's attitudes towards adults who were either 'informal' voluntary clients or those who had been admitted under the Mental Health Act (1983) to an inpatient ward were explored in the empirical paper. The attitudes of nursing staff have the potential to impact on the development of therapeutic relationships and therefore upon treatment outcomes. Repertory grid interviews were completed with twelve nursing staff. All staff made critical judgements about some of their clients; however, staff who used more dimensions to construe clients made less clear distinctions between clients and non-clients. The findings highlight the need for support mechanisms that enable staff to formulate clients' difficulties and explore the complexity of interactions. The implications of these results are discussed, as well as future research directions.

The final paper consists of a critical reflection of the research and the research process. This includes an evaluation of the decision making processes and discussion of the strengths and weaknesses of this research.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Dedication

This thesis is dedicated to my Nan, Margaret France, a bionic woman. I will endeavour to hold onto the resilience, strength and acceptance you have demonstrated in the face of adversity.

Acknowledgements

I would like to thank all my family for all their support over the past three years, it's been a journey filled with new adventures and challenges and they have stuck by me every step of the way. I'd like to thank my husband, John, for the unwavering support and strength he has given me, especially at times when I needed it the most. My parents, Carole and Henry, who have always believed in me and who have given me the opportunities that have led me to where I am today.

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Paper 1: Systematic Review

Nursing staff attitudes towards those experiencing mental illness:

A literature review

Manuscript prepared in accordance with *Clinical Psychology & Psychotherapy*
guidelines (Appendix A)

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Abstract

Supporting those experiencing severe mental health difficulties is a principal focus of the WHO's European Regions long-term strategic health policy. As the largest health care profession in Europe, nurses are the front-line staff. Their professional attitudes towards individuals are essential for high-quality care to aid recovery. This review aimed to provide an insight into European nursing staff's attitudes towards those experiencing mental health difficulties who require support from acute inpatient and outpatient/community mental health services. Six databases were searched and a total of 14 cross-sectional studies were identified. This review identified that the role of personal experiences of mental health difficulties through friends or family members was shown to elicit more positive attitudes. Overall attitudes amongst nursing staff were varied, yet factors that influenced these attitudes were less clear and consistent. Supporting staff to engage in personal and professional development within the workplace may enable them to manage difficult interactions when they arise and allow nursing staff to become aware of and challenge their own negative attitudes towards those they support.

Keywords: attitudes, mental health, mental illness, nursing, psychiatric nursing

Key Practitioner Message:

- Personal experiences of mental health difficulties through friends or family members may result in staff holding more positive attitudes.
- Nursing staff with more years of experience were more socially accepting of those with mental health difficulties.
- Type of contact may influence attitudes, with those working in inpatient settings experiencing more continuous and intense interactions with individuals.
- In general, nursing staff in Europe hold varying attitudes towards those with mental health difficulties.

Introduction

In Europe approximately 1-2% of the population are diagnosed with psychiatric disorders and more than a third of the population experience mental health difficulties every year, with four out of 15 people experiencing severe anxiety and/or depression (World Health Organisation [WHO], RC63, 2013). Supporting individuals with mental disorders¹ is one of Europe's greatest public health challenges, due to the financial costs and the significant loss of life each year, with an average of 13.9 people per 100,000 dying by suicide within the European Region (RC63, 2013).

A fundamental part of the European Union's (EU) and the WHO's long-term strategic policy objectives (European Pact 2008; WHO, 2013, 2015) is to strengthen mental health and to improve the quality of life of those experiencing mental health difficulties; however, stigma and discrimination can present significant obstacles, impacting on access to services and increasing health inequalities (Hatzenbuehler, Phelan & Link, 2013). Although 21 European countries and regions have actively implemented anti-stigma campaigns since 1998 (Borschmann, Greenberg, Jones & Henderson, 2014), the general public continue to have stigmatizing attitudes towards persons with mental illness, with some identifying that public attitudes have not changed for the better and have even deteriorated towards persons with schizophrenia (Angermeyer, Matschinger & Schomerus, 2013). In contrast, positive changes in the general public's attitudes towards those experiencing mental health difficulties, with reductions in the level of discrimination experienced by individuals, have been reported in England (Evans-Lacko, Corker, Williams, Henderson & Thornicroft, 2014). However, across Europe many people with mental health problems choose not to engage or maintain contact with mental health services, due to stigma and discrimination (McDaid, 2008; WHO, 2013).

¹Defined by the WHO as: comprising a broad range of problems, with different symptoms. Generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.

The attitudes of mental health professionals towards service users are especially important because they influence the development of a therapeutic relationship, which has the capacity to bring about change for clients (Barker, Reynolds & Stevenson, 1997). This is particularly relevant for those accessing inpatient and rehabilitation care, when individuals are most vulnerable and have high levels of contact with mental health nursing staff. Thus, the therapeutic relationship between staff and clients depends upon nursing staff's ability to contain their responses and attitudes in the face of intense interpersonal interactions (Gallop & O'Brien, 2003).

In her systematic review exploring several aspects of the relationship between mental health professionals and stigma, Schulze (2007) identified nine surveys of mental health professionals' attitudes towards service users and concluded that there was an 'inconsistent picture' with regards to professional attitudes, particularly as professionals were found in part to hold either more positive attitudes, similar or more negative attitudes than the general public. Schulze (2007) concluded that mental health professionals should be a target group for anti-stigma campaigns.

Building on Schulze's (2007) review, Wahl and Aroesty-Cohen (2010) reviewed 19 studies published between 2004 and 2009 and explored the attitudes of mental health professionals (psychiatrists, psychologists and psychiatric nurses) working closely with individuals with psychiatric disorders. Fourteen out of 19 studies noted overall positive attitudes of mental health professionals towards service users with psychiatric disorders, with five studies reporting only negative attitudes. However, negative attitudes were also present even in studies with overall positive attitudes, again indicating mixed findings amongst mental health professionals' attitudes. Despite the insightful findings, Wahl and Aroesty-Cohen (2010) did not identify factors that might account for emergent positive or negative findings. Similarly to Schulze (2007), they did not identify differences between professional groups and whether this influenced attitudes.

In their review of 26 studies relating to nurses' attitudes towards mental illness, Ross and Goldner (2009) identified the role of nursing professionals as both 'stigmatisers' and the 'stigmatised' in line with Schulze's (2007) findings. They reported that nurses played the role of perpetrators of stigmatising attitudes towards those with psychiatric illness. In particular, nurses in general medical settings often held negative attitudes of fear, blame and hostility towards patients with psychiatric illness, whilst nurses who chose to work in psychiatric settings were also found to hold pessimistic attitudes. Although their review provided an understanding of nurses' attitudes, it primarily focused on negative and stigmatising attitudes. Furthermore, it did not offer possible explanations as to the reasons why such attitudes had been reported.

Given their vital role, understanding the attitudes of nursing staff is highly relevant to an individual's care and recovery. Thus, the current systematic review aimed to a) explore the attitudes of European nursing staff towards clients experiencing mental health difficulties who access support from mental health services, b) identify influencing factors that explain differences in attitudes including socio-demographic variables and c) whether employment type (e.g. working on acute inpatient wards versus community rehabilitation services) influenced attitudes.

Methodology

Seven databases including PsychINFO, Medline, Embase, Psych Articles, Cinahl Plus, Web of Science and PubMed were searched systematically. Reference lists of included papers were searched for relevant articles and citation searches were completed on included papers. Search terms included "nurs* OR psychiatric nurs*" OR "mental health staff" OR "mental health professionals" AND "mental health OR mental illness" OR "psychiatric disorder" AND "attitud*".

Only articles that involved empirical quantitative self-report questionnaire studies undertaken in European Countries² and were published in English in peer-reviewed journals between January 2007 and March 2016³ were selected for review. Studies that explored only nursing staff attitudes towards a specific clinical population (e.g., those with borderline personality disorder, schizophrenia) as well as studies of general attitudes towards those experiencing acute mental illness were included. Studies exploring other mental health professionals' attitudes were only included if nursing staff attitudes were reported separately. Studies that focused on specific aspects of treatment, such as restraint techniques, were excluded. Additionally, studies that used qualitative (interview studies) or mixed methodologies were excluded alongside studies assessing psychometric properties of attitude scales/questionnaires. Studies that assessed only student attitudes were also excluded because student nurses were still in training.

Figure 1, based on PRISMA guidelines (Moher, Liberati, Tetzlaff & Altman, 2009), illustrates the search process.

Quality appraisal tool

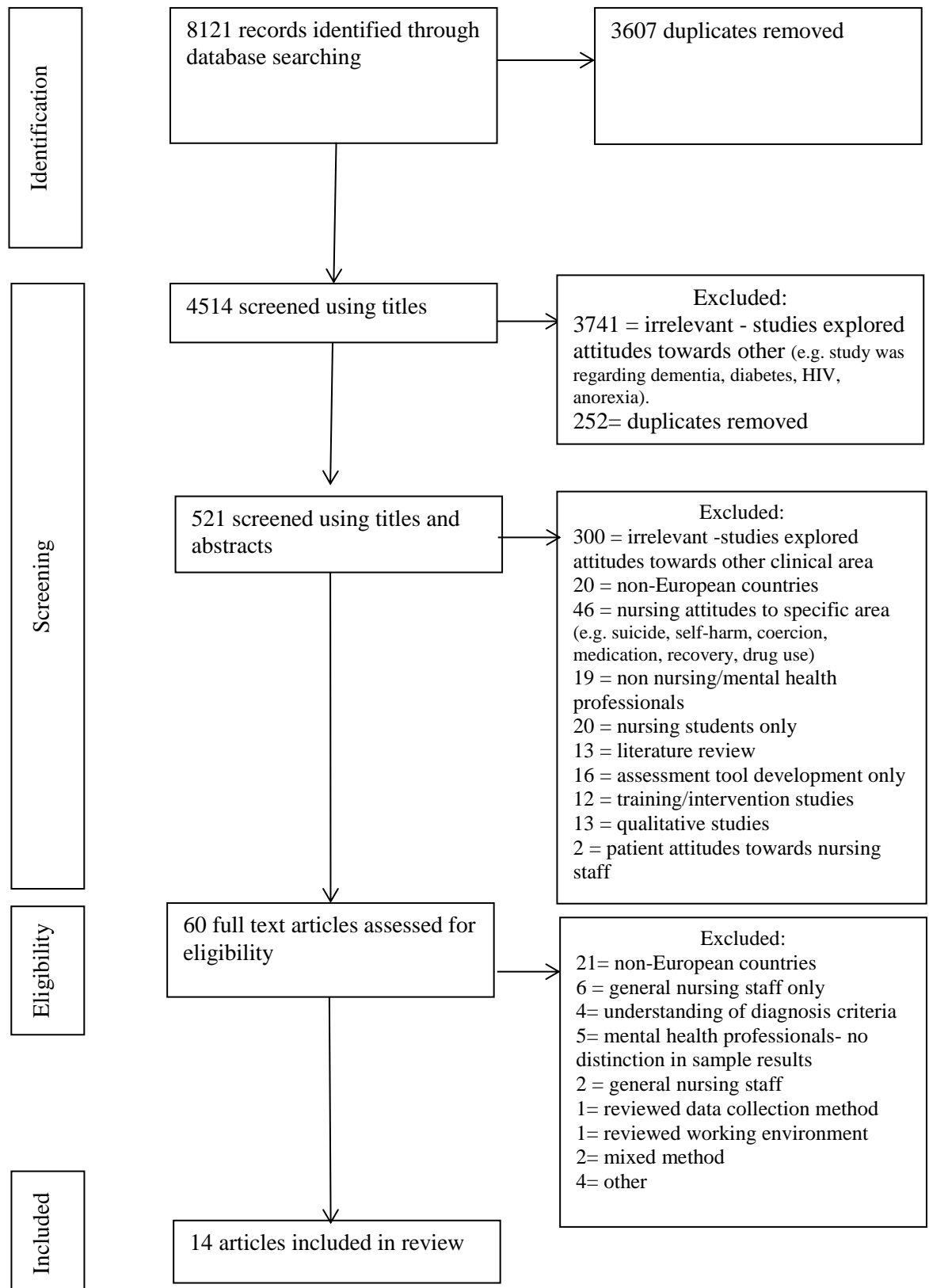
The Effective Public Health Practice Project (EPHPP) quality assessment tool for quantitative studies was chosen and adapted (Appendix B) to review the quality of cross-sectional questionnaire studies. The following sections were omitted because they were not applicable for the studies selected for review: Section B (study design); Section D (blinding); Section G (intervention integrity) and Section H (analyses; however, Q3 in this section was addressed). Consistent with other uses of this measure, studies were rated as strong if there were no weak ratings; moderate with one weak rating or weak if two or

² This was defined as all 53 countries that are identified as Member states of the WHO European Region (2013)

³ This time period was selected because a number of anti-stigma campaigns have been implemented since 2007 including the Time to Change anti-stigma campaign in England (Borschmann, et al, 2014). Studies prior to 2007 might have reported dated attitudes, therefore not reflecting more recent nursing staff's attitudes.

more weak ratings were given. A peer, unconnected to the study, independently rated 50% of papers and any discrepancies were resolved through discussion.

Figure 1: Flowchart demonstrating literature review procedure



Results

The findings in Table 1 illustrate the features of the reviewed studies. Fourteen cross-sectional questionnaire studies were identified. Six studies included nursing staff from the UK and Ireland, three from Sweden, three from Israel, one study was from Turkey, and one study explored staff attitudes across five European countries⁴. All 14 studies included nursing staff working in various mental health settings, including acute inpatient psychiatric care wards in both general hospital sites and specialist mental health/psychiatric hospital sites and community mental health services; one study included nursing staff working for council-led inpatient and outpatient mental health services and community support in residential settings. As can be seen in Table 1, a diverse range of questionnaires were used, with the Community Attitudes Towards Mental Illness (CAMI) being the most common.

Quality assessment of reviewed studies

In relation to the quality of the reviewed studies, a number of limitations can be identified. Nine of the 14 studies were rated as 'weak', three as 'moderate' and two as 'strong' according to the criteria outlined by the EPHPP tool (Appendix C). Inter-rater reliability was good (Kappa = .74). These results were primarily due to the number of participants recruited in the studies being less than 60% of the possible participant pool. Additionally, studies did not indicate if they controlled for confounding variables and the questionnaires used by James and Cowman (2007), Kukulcu and Ergun (2007), Bjorkman et al. (2008) and Bodner et al. (2011) were not validated.

⁴ Countries were defined as Member states of the WHO European Region (2013).

Table 1: Demographic characteristics and study outcomes

No.	Author(s)	Country	Setting	Staff demographics & sample size	Questionnaire/ Technique used	Outcome
1	James & Cowman (2007)	Ireland	Mental health inpatient and outpatient services	<p>157 mental health nurses 65 responded (41.4%).</p> <p>36 acute inpatient unit/rehabilitation unit 28 Community Services 1 unknown</p> <p>21 male. 44 female.</p> <p>Most common age group 40-49 years.</p> <p>Most common length of experience 2-5 years.</p>	Unnamed questionnaire assessing knowledge and understanding of BPD, diagnosis, treatment and prognosis, beliefs about role working with patients with BPD.	<ul style="list-style-type: none"> 75% of nurses found those with BPD very or moderately difficult to look after. 1.5% of nurses believed that those with BPD were easier to care for than those with other psychiatric disorders. Nurses tended to believe that individuals with BPD could be treated successfully and that nurses had an appropriate role in that treatment.
2	Kukulu & Ergun (2007)	Turkey	Psychiatric wards of 27 university hospitals, 6 training/research hospitals and 6 psychiatric hospitals	<p>693 nurses working on psychiatric wards. 543 responded (78.3%).</p> <p>Mean age of nurses 32.3 years.</p> <p>No gender differences obtained.</p>	Unnamed questionnaire based on existing literature.	<ul style="list-style-type: none"> 31.9% thought that people diagnosed with schizophrenia should not move freely in society. 56.7% thought that they could work with a person diagnosed with schizophrenia. 76% of nurses stated people with schizophrenia are aggressive 80.7% nurses believed individuals are not able to make decisions affecting their own lives. 47% of participants agreed that schizophrenia is emotional weakness.

3	Munro & Baker (2007)	England	Acute Mental Health units.	<p>251 staff invited to participate. 140 responded (55.8%).</p> <p>92 qualified (psychiatric) nurses. 48 nursing assistants.</p> <p>88 female. 52 male.</p> <p>Mean of 9.92 years of experience.</p>	Attitudes towards Acute Mental Health Scale (ATAMH)	<ul style="list-style-type: none"> • Overall generally (80%) positive attitudes towards those in acute mental health care were identified. • Differences between qualified and unqualified nursing staff attitudes for some questions with qualified nurses showing more positive attitudes.
4	Webb & McMurrin (2007)	Wales	Community Mental Health team (CMHT).	<p>117 nurses working within 12 CMHT services.</p> <p>88 nurses from CMHT & 29 CMHT nurses attended PD awareness workshop.</p> <p>No demographic data was collected.</p>	Attitude to Personality Disorder (PD) Questionnaire (APDQ).	<ul style="list-style-type: none"> • CMHT nurses enjoy working with those with PD but feel less secure working in a community setting, less accepting and less purposeful. • Volunteers at a PD awareness workshop reported significantly higher levels of enjoyment, security, acceptance and purpose, plus a higher overall total score on the APDQ.
5	Bjorkman, Angelman & Jonsson (2008)	Sweden	Psychiatric care- acute and rehabilitation settings (and somatic care acute and ward settings)	<p>150 Nursing staff. 120 responded (80%).</p> <p>51 Psychiatric care Nurses: 21 qualified nurses. 30 nursing assistants.</p> <p>34 (67%) female. 17 (33%) male.</p> <p>Mean age 44 years.</p> <p>Mean years of experience 25 years.</p>	<p>Attitudes towards Persons with Mental Illness Questionnaire.</p> <p>Level of Familiarity Questionnaire.</p>	<ul style="list-style-type: none"> • Psychiatric nurses, were less likely to see individuals with schizophrenia or drug addiction as dangerous, unpredictable, and hard to talk to. • Negative correlations were reported between amount of professional experience and perceptions of people with schizophrenia as dangerous and unpredictable. • No difference between registered nurses and nursing assistants. • Those with more personal connections i.e. family/friends with mental health difficulties had more positive attitudes towards those they supported.

6	Roa, Mahadeva ppaPillay, Sessay, Abraham & Luty (2009)	England	Acute mental health hospitals and general Medical hospital	<p>200 mental health professionals. 108 (54%) responded.</p> <p>62 qualified nurses. 14 healthcare assistants. 22 doctors. 10 unknown.</p> <p>38 worked in acute hospital settings. 56 in mental health settings. 14 unknown.</p>	Attitude to Mental Illness Questionnaire (AMIQ) with vignette describing patient with: a) acute psychotic episode b) admitted to forensic hospital c) schizophrenia who had recently taken an overdose. Part 2: either a) negative control vignettes or b) positive vignettes	<ul style="list-style-type: none"> • More stigmatized attitude towards the hypothetical individual with schizophrenia. • More favourable opinion from those who were informed individual was abstaining from use of opiates/alcohol. • No significant difference between mental health staff and those from other backgrounds.
7	Chambers, Guise, Valimaki, Botelho, Scott, Staniuliene & Zanotti. (2010)	Europe (Ireland Finland Lithuania Italy Portugal)	Acute inpatient wards within psychiatric hospitals. Community mental health facilities. Acute mental health units at general hospitals.	<p>1095 registered mental health nurses from psychiatric inpatient wards, acute units and community facilities. 810 responded (74.2%). 646 Nurse staff 113 Nurse manager 51 other</p> <p>Female Nursing staff %: 99% Lithuania; 63% Italy; 53% Portugal; 52% Finland; 33% Ireland.</p> <p>Mean age 41.1 years.</p> <p>Mean of 18.52 years of nursing experience.</p>	Community Attitudes towards Mental Illness (CAMI) Questionnaire	<ul style="list-style-type: none"> • Nurses were found to have positive attitudes to mental illness. • Overall, Portuguese nurses held more positive attitudes, whilst • Lithuanian nurses held most negative attitudes. • Female nurses were found to have a more sympathetic attitude to those living with mental illness and to be more positive to community care than male nurses. • Staff nurses were consistently more negative in their attitudes than nurse managers and other.

8	Bodner, Cohen-Fridel & Iancu (2011)	Israel	Psychiatric hospitals.	57 mental health professionals 25 psychiatric nurses. 19 psychiatrists. 13 psychologists. 37 female. 20 male. Mean age of 41.4 years	Borderline patients– Cognitive Attitudes and Treatment inventory & Borderline patients– Emotional Attitudes inventory	<ul style="list-style-type: none"> • Nurses were less empathic compared with psychiatrists and psychologists. • All clinicians reported similar emotional attitudes regarding experience, difficulties and negative emotions towards the treatment of individuals with BPD. • Nurses perceived that treatment should combine emotional support, containment and psychotherapeutic and pharmacological treatment.
9	Hansson, Jormfeldt, Svedberg & Svensson (2011)	Sweden	Mental health services	280 mental health professionals 140 responded (50%) 76 psychiatric nurses. 37 assistant nurses. 27 other. 98 female 40 male. Mean age of 46 years. Mean experience of 16 years.	12-item Perceived Devaluation-Discrimination Questionnaire	<ul style="list-style-type: none"> • Negative attitudes towards people with mental illness in relation to employment, personal relationships and positions of responsibility for children were found. • Staff caring for individuals experiencing psychosis and staff working in inpatient settings held more negative attitudes compared to staff treating other diagnostic groups and staff working in outpatient settings.
10	Linden & Kavanagh (2012)	Ireland	Inpatient and Community Mental Health	177 qualified Mental Health Nurses (MHN). 121 responded (68%) 68 inpatient settings. 42 community settings. 11 unknown. 66 female. 55 male. Mean age of 41 years Mean of 19.29 years of experience.	Community Attitudes towards Mental Illness (CAMI) Questionnaire + Social Interaction Scale (SIS)	<ul style="list-style-type: none"> • No significant difference between student and qualified nurses' attitudes. • Nurses employed in a community setting held more positive attitudes, compared nurses working in inpatient setting. • Nurses in inpatient setting held more socially restrictive attitudes: that individuals with schizophrenia were dangerous and should be avoided.

11	Tyson (2013)	England	Acute Psychiatric mental health unit.	<p>200 nursing staff: 54 responded (27%).</p> <p>35 RMN's/trainee RMNs. 17 HCAs/trainee HCAs. 2 Associate practioners</p> <p>38 female 16 male.</p> <p>Most frequent age group 27-35 years</p> <p>Mean experiance of 9.4 years.</p>	Attitudes towards Acute Mental Health Scale (ATAMH) modified	<ul style="list-style-type: none"> • Generally positive attitudes were observed. • Differences between strength of opinion express between RMNs/trainee RMNs and HCAs/trainee HCAs • Younger staff were more tolerant/open to helping those who were emotionally disturbed. • More experienced staff disagreed with the use of control and restraint techniques. • More experienced staff also perceived mental illnesses to be genetic.
12	Martensson Jaconsson & Engstrom (2014)	Sweden	County Council led Inpatient and outpatient settings and residential care and home support	<p>393 mental health nursing staff. 256 responded (65%). 83 county council (inpatient and outpatient) 173 municipalities- (residential homes/ home treatment.)</p> <p>22 Registered nurse 27 Hospital orderly 177 Assistant nurse 29 Specialist licensed nurse</p> <p>186 females 69 males</p>	<p>Community Attitudes towards Mental Illness (CAMI) Questionnaire Swedish version.</p> <p>Mental Health Knowledge Schedule (MAKS)</p> <p>Reported and Intended Behaviour Scale (RIBS)</p>	<p>Nursing staff held more positive attitudes towards persons with mental illness:</p> <ul style="list-style-type: none"> • if their knowledge about mental illness was less stigmatized, • if they worked in inpatient or outpatient settings • if they currently had, or have once had, a close friend with mental health problems.

13	Bodner, Cohen-Fridel, Mashiah, Segal, Grinshpoon, Fischel & Iancu (2015)	Israel	Psychiatric hospitals	<p>710 mental health professionals. 691 responded (97%) of all professionals – 47% of nurses.</p> <p>262 mental health nurses 167 psychiatrists 162 psychologists 100 social workers</p> <p>440 female: (155 nurses 249 male: (105 nurses)</p> <p>Average age of 44.62 years.</p>	<p>Borderline patients– Cognitive Attitudes and Treatment inventory & Borderline patients– Emotional Attitudes inventory</p>	<ul style="list-style-type: none"> • Nurses reported more negative cognitive attitudes towards individuals with BPD. • Nurses reported more negative emotional attitudes towards individuals with BPD-difficulty to treat negative affect and lack of empathy. Nurses worked more regularly with individuals with BPD compared to psychologists and social workers
14	Ben-Natan, Drori & Hochman (2015)	Israel	Psychiatric Hospital and general hospital	<p>250 nurses. 216 responded (86%).</p> <p>108 psychiatric nurses. 108 non-psychiatric nurses.</p> <p>157 female (73 psychiatric nurses. 59 male (35 psychiatric nurses).</p> <p>Mean age of psychiatric nurses 43.9 years.</p>	<p>Community Attitudes towards Mental Illness (CAMI) Questionnaire</p> <p>Attitudes towards Acute Mental Health Scale (ATAMH) short version</p>	<ul style="list-style-type: none"> • Psychiatric nurses had more positive attitudes towards individuals with mental illness. • Psychiatric nurses believed that individuals with mental illness should not be isolated from the rest of society and that hospitalisation is not the only way of treating individuals with mental illness. • Correlation between stigma towards psychiatric nurses/role of psychiatric nursing and between stigma towards mental illness and individuals with mental illness. Older non-psychiatric nurses demonstrated more stigma towards psychiatric nurses and their role, in addition the older the nurse the greater the stigma towards mental illness.

Attitudes towards service users experiencing mental health difficulties

Positive attitudes. Seven studies, of which two were rated as ‘strong’ in relation to quality assessment ratings, three as ‘moderate’ and two as ‘weak’, reported positive attitudes among nursing staff towards persons experiencing mental health difficulties. One study which was identified as ‘strong’ in quality rating identified that nursing staff working in both inpatient and outpatient services were generally more positive compared to the general population, in particular, nursing staff were more positive if their knowledge about mental illness was less stigmatised and they had a close friend with mental health difficulties (Martensson et al., 2014). Two ‘weak’ studies (Munro & Baker, 2007; Tyson, 2013) showed that acute inpatient nurses held generally positive attitudes, with nurses disagreeing that those experiencing mental health difficulties have no control over their emotions and that society was at risk from those experiencing mental illness (Tyson, 2013). Nurses also disagreed with statements around personal qualities depicting those experiencing mental health difficulties as ‘difficult’, ‘violent’ and ‘weak in personality’ (Munro & Baker, 2007). One ‘moderate’ rated study identified that in comparison to somatic care nurses, nurses in psychiatric care had more positive attitudes, particularly towards individuals with schizophrenia or drug addiction, who they viewed to be less dangerous, less unpredictable, and not difficult to talk to (Bjorkman et al., 2008).

Another study rated as ‘moderate’ highlighted that positive attitudes towards those with a diagnosis of schizophrenia were endorsed by nursing staff working within community settings, who favoured the integration of services for individuals with schizophrenia into communities. They believed that residents had ‘nothing to fear from such facilities’. They were also more willing to engage socially with individuals who had schizophrenia (Linden & Kavanagh, 2012). A further ‘moderate’ rated study by Natan and colleagues (2015) reported that psychiatric nurses believed in social acceptance,

specifically that individuals with mental illness should not be isolated from the rest of society and that hospitalisation was not the only way of treating individuals. Chambers and colleagues (2010) whose study was also rated as ‘moderate’ noted generally positive attitudes towards those with mental health difficulties amongst European nursing staff. However, differences at macro-level amongst countries existed with nurses from Lithuania holding more negative attitudes generally.

Negative attitudes. Seven studies all of which were rated as ‘weak’ in relation to the quality assessment rating reported negative attitudes towards those experiencing mental health difficulties. Hansson and colleagues (2011) identified negative attitudes towards people with mental illness amongst mental health professionals, of which the largest participant sample was mental health nurses and nursing assistants (81.9%). Nurses endorsed attitudes that concerned employers passing over an individual with mental health difficulties in favour of someone without, individuals not wishing to date someone with mental health difficulties and concerns around an individual with these difficulties having caring responsibility for children. Staff caring for those with psychosis held more negative attitudes, perceiving individuals as less trustworthy, less likely to be hired by employers and that their opinions would be taken less seriously. However, nursing staff held more positive attitudes than patients and disagreed that entering a mental health hospital was a sign of personal failure, that people thought less of a person who had been in a mental health hospital, and that people would take a person’s opinion less seriously if they had been in a mental health hospital.

Rao and colleagues (2009) provided staff with three case vignettes describing individuals with different mental health difficulties alongside completing a questionnaire. Stigmatizing attitudes were most common towards people with schizophrenia and the individual admitted to a more secure hospital. In the second part of their study, staff were given one of two vignettes, one which described a person who was actively using alcohol

or opioids and one which described an individual abstaining from alcohol or drug use. When individuals with active opioid dependence and alcoholism were presented as abstaining from drug and alcohol use as well as holding employment staff perceived the individual in a more positive light. Rao et al. (2009) did not provide a detailed breakdown of staff demographics, they indicated that qualified nurses were the largest participant sample (58%). Although Rao et al. (2009) found mental health staff attitudes did not significantly differ from other health professionals, it is possible that the negative attitudes identified in their study might represent attitudes of a wider professional group and not just those of mental health nurses alone because they did not assess how many nursing staff worked within mental health services.

Negative attitudes were also found amongst nursing staff working with those diagnosed with borderline personality disorder (BPD). Bodner et al. (2011; 2015) identified that inpatient staff lacked empathy and demonstrated more antagonistic attitudes toward persons with BPD compared to psychologists and social workers but not compared to psychiatrists. Additionally, nurses were found to exhibit more negative attitudes and perceived individuals with BPD as more difficult to treat in comparison to persons with a clinical diagnosis of major depressive disorder or generalised anxiety disorder. However, Bodner et al. (2015) noted that although nurses mostly held negative opinions, they acknowledged the complexity and understood the need for different disciplines to combine efforts to support individuals.

James and Cowman (2007) reported that three quarters of nurses in inpatient and outpatient services found individuals with BPD moderately to very difficult to care for and 80% agreed that those with BPD were more difficult than other individuals experiencing mental health difficulties. This study also reflected that nurses believed that those with BPD could be treated successfully and that nurses had an appropriate role in that treatment. Community mental health nurses expressed more enjoyment working with

individuals with personality disorder but identified lower levels of feeling secure/safe, acceptance and purpose when working with people with personality disorder (Webb & McMurrin, 2007).

Kulukulu and Ergun (2007) identified that 76% of mental health nurses perceived persons with a diagnosis of schizophrenia as aggressive, 80.7% believed individuals were not able to make decisions affecting their own lives and 47% of nurses believed that schizophrenia was a state of emotional weakness. In addition, 84.3% of nurses stated they agreed that people diagnosed with schizophrenia could not completely recover and only half stated that they could work with a person with schizophrenia. In their study exploring nursing staff attitudes, Linden and Kavanagh (2012) discovered that inpatient nursing staff held more socially restrictive attitudes, i.e. they felt individuals with schizophrenia were dangerous and should be avoided.

Factors influencing nursing staff attitudes

Work place. Place of work was found to be related to nursing staff attitudes, although the findings were contradictory. One ‘strong’ study (Martensson et al., 2014) reported that nursing staff who worked in inpatient and outpatient rehabilitation settings held more positive attitudes than those working in residential settings and with people in their own home. Nursing staff working within inpatient and outpatient rehabilitation settings were more likely to encounter patients who recovered and returned to an active life in society. In contrast, one ‘weak’ study (Hansson et al., 2011) and one ‘moderate’ study (Linden & Kavanagh, 2012) found that nursing staff working in inpatient mental health settings held more negative attitudes towards individuals than those working in outpatient and community services. .

Gender. Three studies, one of which was rated as ‘weak’ (Munro & Baker, 2007), one as ‘moderate’ (Bjorkman et al., 2008) and one as ‘strong’ (Chambers et al., 2010)

examined demographic differences and identified that female nursing staff held more positive attitudes than male nursing staff. Chambers et al. (2010) identified that female nursing staff held more sympathetic attitudes and were more positive with regards to community care. In terms of supporting individuals with schizophrenia or depression, male nursing staff were more pessimistic in relation to individuals improving with treatment and “being capable of pulling themselves together” (Bjorkman et al., 2008). Although no gender differences were found for total scores, Munro and Baker (2007) identified gender differences relating to specific attitudes, with more male staff perceiving society being at risk from those experiencing mental health difficulties, that depression occurred within individuals who had a weak personality and that it was more difficult to negotiate care plans with individuals in acute settings (Munro & Baker, 2007). Two studies rated as ‘weak’ (Tyson, 2013; Hansson et al., 2011) did not observe any differences in the attitudes of male and female nursing staff.

Nursing staff position. Only four of the studies explicitly explored the association between attitudes and nursing staff position. Mixed findings were reported with one ‘moderate’ study identifying no difference between qualified nurses’ and student nurses’ attitudes (Linden & Kavanagh, 2012), and another ‘weak’ study finding no difference between qualified nurses’ and nursing assistants’ attitudes (Tyson, 2013). In contrast, Munro and Baker (2007) reported that in comparison to nurses, nursing assistants perceived those with schizophrenia as more incapable of looking after themselves as well as perceiving individuals as more ‘cold-hearted’. However, nursing assistants were more inclined to perceive mental illness as a result of adverse social circumstances. In their study rated as ‘strong’, Chambers and colleagues (2010) also highlighted differences between nursing staff position and reported that staff nurses working on wards held more negative attitudes than nurse managers.

Experience. A number of studies reported an association between nursing staff attitudes and years of experience. Two studies rated as ‘moderate’ found that years of nursing experience impacted on an individual’s willingness to socially interact with those with schizophrenia; staff with 10 to 14 years of experience were identified as more accepting (Linden & Kavanagh, 2012). Supporting this finding, Bjorkman et al. (2008) found that nurses with more years of experience held less negative attitudes about persons with schizophrenia concerning dangerousness, unpredictability and having themselves to blame for their disorder. Those with more years of experience also held more positive attitudes about the prospect of recovery from severe depression, panic attacks and drug addiction. A further study rated as ‘weak’ (Tyson, 2013) noted that those with more years of experience disagreed with the use of control and restraint technique in comparison to staff members with less experience. However, one study that was rated as ‘weak’ (Hansson et al., 2011) failed to observe a significant association between attitudes and years of experience.

Age. In relation to age only two studies explicitly explored the influence of age on attitudes. One study rated as ‘moderate’ (Bjorkman et al., 2008) reported positive correlations between age and less negative attitudes about persons with schizophrenia concerning dangerousness, and unpredictability, whereas Tyson (2013) observed that those over 55 years of age found it more difficult to help patients who were emotionally disturbed, suggesting that younger staff were more tolerant and open to helping those who were emotionally disturbed.

Personal experiences of mental illness. The influence of personal experiences with regards to knowing or having a friend or family member with mental health difficulties was found to be associated with more positive attitudes in two studies which were described as ‘strong’ (Martesson et al., 2014) and ‘moderate’ (Bjorkman et al., 2008) in line with the quality rating assessment. According to Martesson and colleagues (2014),

those who know or have known someone with mental health difficulties demonstrated more positive attitudes towards individuals who they cared for. Bjorkman et al. (2008) reported that 25% of their participants had a friend/ relative who had a mental illness or had lived with a person who has a severe mental illness. Those with a higher ranking score of intimacy with individuals with mental illness found it easier to talk to persons with schizophrenia, and had less negative attitudes regarding persons with schizophrenia being to blame for their disorder. Additionally, they had a more positive attitude about prospects for improvement with treatment and recovery from severe depression (Bjorkman et al., 2008).

Discussion

The aim of this review was to expand insight into the attitudes of European nursing staff towards those experiencing severe mental health difficulties and the factors that influenced these attitudes. The findings indicated that there remained varying attitudes amongst nursing staff towards those experiencing mental health difficulties. Positive attitudes in relation to acceptance of those with mental health difficulties within community settings and services were identified. Nursing staff working in a variety of settings also perceived those with more complex and interpersonal difficulties as more challenging to treat and support, with some nursing staff members endorsing statements about individuals experiencing mental health difficulties as untrustworthy and dangerous.

Factors that influenced these attitudes were less clear, with inconsistencies being reported in relation to gender, age and experience, staff position and work place. One factor that was found to influence positive attitudes was having personal experience of someone with mental health difficulties. Studies that explored the impact of personal relationships/friendships with individuals with mental health difficulties found nursing staff with such connections held more positive attitudes. This is consistent with other

research which reported that personal experiences resulted in some nursing staff perceiving there to be less of a distinction between clients and themselves (Ralley, Allott, Hare & Wittkowski, 2009; Blundell, Wittkowski, Wieck & Hare, 2011). Although there were inconsistencies regarding staff position and work place, there is perhaps a link between attitudes and the type of contact nursing staff have with those experiencing mental health difficulties. Front line nursing staff in inpatient services held more negative views than psychologists, social workers and nurse managers (Bodner et al., 2015; Chambers et al., 2010). Furthermore, nursing staff in inpatient settings also held more negative attitudes than those in outpatient and community services (Linden & Kavanagh, 2012). This finding is perhaps not unexpected given that nursing staff working on inpatient wards work long continuous shifts and may not have the time or resources to be able to manage or understand individuals' distressed behaviours (Staniulienė et al., 2013), particularly given the increased focus on risk management (Muir-Cochrane et al., 2011). Additionally, violence and aggression towards nursing staff have been reported, with an estimated 70% of nursing staff working in UK inpatient settings having been assaulted at least once during their career (Needham et al., 2005). This understandably impacts upon staff morale (Totman, Hundt, Wearn & Johnson, 2011) and can result in negative cognitive and emotional reactions, with staff distancing themselves from individuals on the wards (Duxbury & Whittington, 2005). Furthermore, when incidents on the ward occur it is not possible for inpatient ward staff to 'escape' the fall out of confrontations so easily, consequently the emotions of one team member can then influence the whole team (Cleary, Walter & Hunt, 2005). Other professional groups and those working within community settings may not experience these intense personal interactions as often as front line inpatient nursing staff and are also more likely to be able to leave the environment more readily. Additionally, psychologists and social workers also have mechanisms for support in the form of clinical supervision to explore arising difficulties.

Understanding the mechanisms behind nursing staff attitudes requires further investigation.

Although only three studies in the current review have also been included in two previous reviews, the findings of the remaining 11 studies were consistent with other reviews in this area (Schulze, 2007; Wahl & Aroesty-Cohen, 2010). The current review underlined that nursing staff held both positive and negative attitudes towards those with mental health difficulties; however, it is important to consider the quality assessment rating of these studies and the methodological approach the reviewed studies used. The methodological quality of those studies identifying positive attitudes was mixed with two rated as 'weak', three as 'moderate' and two as 'strong'. The interpretation for these study findings can therefore be considered generally reflective of nursing staff attitudes. In contrast, all those reporting negative attitudes were rated as 'weak', which was due to these studies having low respondent rates. Additionally, three of these studies did not use validated questionnaires, and five of the seven studies failed to control for differences amongst participants; for example work place/location and education. Therefore these results should be taken tentatively, particularly given that questionnaires can place an emphasis on the information the researchers deem important. The findings may be a by-product of the way the questionnaires assessed different areas of attitudes. There is also the risk that questionnaires place limitations on the amount of information that participants can provide, restricting the flexibility for how participants respond (Krumpal, 2013). Furthermore, difficulties in interpreting the underlying meaning of participant responses can mean the researcher is unable to explore participants' responses in order to identify what they truly meant and the mechanisms behind their responses (Visser, Krosnick & Lavrakas, 2000). For example, it would be interesting to know why those nursing staff in Tyson's (2013) study over 55 years of age found it more difficult to help patients who were emotionally disturbed. Tyson (2013) offers some possible explanations

suggesting that the finding may be due to differences in training, a more optimistic outlook of younger staff, or due to older staff holding more ‘institutionalised’ beliefs of the profession; however, these were only speculative. As a result, inferences are often made about participants’ intended meaning, thus threatening the ecological validity of the findings. Furthermore, people were asked either about hypothetical clients or to endorse statements on a questionnaire, which does not allow people to talk about real life experiences.

The use of other methodologies that reduce social desirability responses, such as the repertory grid technique, may elicit more personal, relevant and meaningful attitudes as it allows the exploration of staff perceptions about actual clients with whom staff have developed an interpersonal relationship with (Jankowicz, 2004). It also allows researchers to probe participants’ responses in order to identify what they truly mean. This technique has successfully been used to explore nursing staff attitudes (Ralley et al., 2009; Blundell et al., 2011; Addison, Hare & Wittkowski, in submission).

Limitations

Considering the methodological issues described, the findings should be treated with some caution. Due to the lack of specific quality assessment tools for cross-sectional studies, it was necessary to adapt the EPHPP in order to suitably assess methodological quality. The EPHPP was chosen because it provides a quality rating scale and has shown an ability to be an effective and reliable assessment tool for public health studies (Thomas, Ciliska, Dobbins & Micucci, 2004), the STROBE (von Elm, Altman, Egger, Pocock, Gøtzsche & Vandembroucke, 2007) could have been an alternative tool but no quality rating scale is provided.

As this review only explored cross-sectional studies, it was not possible to understand the mechanisms behind nursing staff’s attitudes. Future reviews may therefore

wish to explore whether qualitative studies elucidate this and provide a richer understanding of the mechanisms behind nursing staff's attitudes.

Clinical implications

As nursing staff attitudes towards those experiencing mental health difficulties vary, there may be implications for the development of positive therapeutic relationships. Previous research has highlighted that inadequate staffing levels, particularly within inpatient services, increase the demands upon nursing staff, resulting in staff feeling overworked and tired (Totman et al., 2011). The fact that staff make more socially biased decisions and behaviours, when highly stressed or tired and when decisions need to be made quickly (Moskowitz, 2010), has implications for service providers: adequate staffing could reduce negative attitudes because it would enable nursing staff to provide more one-to-one support and develop better understandings of individuals' behaviours and needs. Furthermore, working in situations where intense and challenging interactions may occur, can ultimately impact upon how staff perceive individuals. A central aspect of nursing care is through the delivery of compassion in practice and this has been reflected in the 6C initiative in the UK (Cummings, 2012) which focuses on putting the person at the centre of the care they receive. Hence it is important to support nursing staff to engage in personal and professional development within the workplace, through the use of mechanisms such as independent clinical supervision and team reflection/formulation practices with qualified professionals. Team formulation has been found to help staff shift towards a more psychosocial understanding of an individual's difficulties, revealing the person behind the diagnosis (Johnstone, 2014). Having these support mechanisms enables nursing staff to explore interactions they find difficult within a structured, contained and emotionally supportive environment that allows staff to acknowledge an individual's needs and their personal story (Johnstone, 2014). This enables staff to become aware of

and challenge negative attitudes towards those they support, ultimately contributing to better patient care through gaining greater compassion. Recent research has shown that for mothers with mental health difficulties compassion was central to their construals of nursing staff and that compassionate care was related to better recovery (Gillham, Hare & Wittkowski, under review).

Conclusion

Although nursing staff hold positive attitudes in relation to acceptance of those with mental health difficulties within community settings and services, negative attitudes were also identified with those with more complex and interpersonal difficulties being perceived as more challenging to care for. Although various factors that influenced nursing staff attitudes were examined, the findings were inconclusive. However, it was identified that the role of personal experiences of mental health difficulties through friends or family members was shown to elicit more positive attitudes, suggesting that staff demonstrate more compassion when they believe those they support are similar to somebody close to them. Further training to aid understanding of behaviours and ongoing clinical supervision to support nursing staff is required.

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Paper 2: Empirical Research Paper

**A repertory grid study of staff construing adult service users admitted to a
psychiatric inpatient ward**

Manuscript prepared in accordance with the *Clinical Psychology & Psychotherapy*
guidelines (Appendix A)

Word count: 8446 for complete manuscript, 7194 for main text.

Abstract

The attitudes of acute mental health nursing staff towards service users experiencing acute mental health difficulties is extremely important given that nursing staff provide front line support for those who access acute inpatient services when they are at their most vulnerable. The attitudes of nursing staff have the potential to impact on the development of therapeutic relationships and therefore upon treatment outcomes. This novel study sought to explore the attitudes of eight psychiatric staff nurses and four nursing assistants, towards clients experiencing acute mental health difficulties who were admitted to an acute inpatient ward, by using the repertory grid technique. A total of 103 constructs were elicited. All staff made critical judgements about some of their clients; however, staff who used more dimensions to construe clients made less clear distinctions between clients and non-clients. Complex clients were construed most differently and negatively to the self which is comparable to how other staff groups construe their clients. In contrast, clients with first time admission were generally construed as most similar to a family relative/friend with mental health difficulties and the hypothetical ideal client. The findings highlight the need for support mechanisms that enable staff to formulate clients' difficulties, explore the complexity of interactions with service users that can occur and through more insight gain greater compassion.

Keywords: nursing staff, attitudes, acute inpatient, mental health, repertory grid.

Key Practitioner Message:

- The construals did not differ between staff nurses and nursing assistants.
- Clients with first time admission in general were construed more preferentially in comparison to those with two or more admissions.
- Opportunities to reflect upon interactions and perceptions of clients can support staff to think about clients in alternative ways and reduce the gap between the self and clients.

Introduction

In 2014/15, approximately 1 in 28 people accessed mental health and learning disability services (Health and Social Care Information Centre [HSCIC], 2015a), and 58,399 people in England were detained in hospital under the Mental Health Act (MHA, 1983), an increase of 42.9% compared to the number of people detained in 2003/04 (HSCIC, 2015b). Although no figures were reported for those who were already in hospital as an informal patient, since 2010/11 there has been a steady increase in the use of Section 5(2) of the MHA (1983) from 7,579 to 9,364 in 2014/15, preventing those who were informally in hospital leaving for up to 72 hours (HSCIC, 2015a).

In order to tackle the negative consequences of stigma around mental health (Henderson & Thornicroft, 2009), the *Time to Change* anti-stigma campaign was launched in England in 2007, followed by the 2011 White Paper Strategy *No Health Without Mental Health*. In 2012, the Compassion in Practice 6C initiative focused on putting the person at the centre of National Health Service (NHS) practice (Cummings, 2012), which was subsequently reflected in the NHS Constitution (NHS, 2013).

Since the introduction of anti-stigma campaigns, the level of public discrimination has reportedly reduced (Evans-Lacko, Corker, Williams, Henderson & Thornicroft, 2014; Time to Change, 2015); however, 1 in 3 mental health service users continue to report stigma and discrimination when they use mental health services, with reports that the level of discrimination in mental health services and other parts of the NHS remains static (Time to Change, 2016). A recent report, *Right Here, Right Now*, identified that services for those experiencing a mental health crisis can lack basic respect, warmth and compassion (Care Quality Commission [CQC], 2015). Given that the role of staff attitudes in providing good quality care is highly important and that negative attitudes can exacerbate stigma and discrimination, understanding the attitudes of those who work closely with people experiencing mental health difficulties is paramount.

Crisis and acute inpatient services are a crucial part of mental health care, providing support and care when people are most vulnerable and unwell (Mind, 2012). Working in acute wards can be demanding, with staff having to manage difficult interactions and challenging behaviour. In addition to other common stressors associated with nursing, psychiatric nurses experience increased stress due to the risk of violence and suicide in service users (Sullivan, 1993). As interpersonal processes within therapeutic relationships can facilitate positive changes for clients (Baker, Reynolds & Stevenson, 1997), individuals have to be capable of containing their emotional responses and attitudes despite intense interpersonal confrontations, in order to develop and maintain positive therapeutic relationships (Gallop & O'Brien, 2003).

Systematic reviews have revealed mixed findings in relation to staff attitudes towards individuals experiencing mental health difficulties. Although overall positive staff attitudes were highlighted, there was evidence that mental health professionals held negative attitudes and expectations, particularly with respect to social acceptance of people with mental illness (Wahl & Aroesty-Cohen, 2010; Addison & Wittkowski, 2016, in submission). Munro and Baker (2007) noted that male staff members held more negative views, whereas Tyson (2013) failed to find any gender differences. Younger nursing staff were found to hold more favourable views towards those experiencing mental health difficulties. Differences between qualified and non-qualified staff were also reported, with non-qualified staff holding both more positive and negative views about people experiencing mental health difficulties than qualified staff (Munro & Baker, 2007).

To date, most studies have used questionnaires together with case or hypothetical client vignettes and/or interviews to explore attitudes towards service users, approaches that are prone to bias due to social desirability (Krumpal, 2013). In addition, interpretation of questionnaire and interview data can be problematic with researchers making

assumptions about the participants' responses and intended meaning. In contrast, the repertory grid technique (Jankowicz, 2004) allows exploration of staff perceptions about actual clients with whom they have developed an interpersonal relationship. As it does not place assumptions upon participant responses, it enables participants to express their views in a meaningful way (Jankowicz, 2004). The repertory grid technique is grounded in Personal Construct Theory (PCT) (Kelly, 1955) which postulates that people actively form representations (*constructs*) of others (*elements*) in order to develop their understanding of the world around them, and to help them make predictions about likely outcomes and patterns of behaviour through the exploration of similarities, differences and themes based upon previous experience. This technique allows the researcher to elucidate a person's views through that person's own idiosyncratic language, thus minimising the impact of social desirability bias (Jankowicz, 2004).

Repertory grids have been used to explore staff attitudes towards clients with mental health difficulties, with Soldz (1992) finding that psychotherapists construed non-psychotic clients more negatively than personal acquaintances and unlike themselves, whereas inpatient psychiatric nursing staff construed clients negatively and different from themselves (Winter, Baker & Goggins, 1992) and nursing students rated psychiatric patients more negatively than medical patients (Wilkinson, 1982). Two recent repertory grid studies exploring staff construal of clients with a dual diagnosis (Ralley, Allott, Hare & Wittkowski, 2009) and of mothers with mental health problems (Blundell, Wittkowski, Wieck & Hare, 2011) identified that all staff made critical judgements about some clients: clients with a personality disorder and those considered a 'bad' mother were viewed as most different to the self (Blundell et al., 2011) and clients with a dual diagnosis and substance misuse were negatively construed, with staff having less judgemental views towards non-clients who used substances (Ralley et al., 2009).

Although the utility of using the repertory grid technique to explore staff construal of clients within a variety of services has been demonstrated, no study to date has used this technique to examine staff views in relation to adult service users admitted to an inpatient psychiatric ward. This study explored whether the cognitive complexity of staff influences construing of clients (including those with first time admissions compared to those with two or more admissions), and how inpatient ward staff construe clients and non-clients in comparison to the self. Additionally the study aimed to explore the relationship between construal of individual client elements.

Methodology

Design

The study utilised the repertory grid interview technique which included both quantitative and qualitative methodological approaches (Jankowitz, 2004). A series of repertory grids were elicited for each participant, providing an idiographic representation of each person's construal of clients, non-clients and themselves. The study was granted full ethical approval by the University Research Ethics Committee (Reference Number: 15157) and the local Research and Development department (Reference Number: 1386) (Appendix D).

Participants

All staff working on an inpatient ward with 31 beds at a North West England NHS Trust were invited to participate if they had a minimum of 12 months experience working on the ward, were permanent members of staff (either part or full-time) and were proficient in English in order to provide informed consent and participate in the interview. Staff were excluded from the study if they were nursing students or bank staff.

Setting

The 31-bed-ward provided inpatient care, including the assessment, development and implementation of individualised care programmes to both male and female adults of working age experiencing significant mental health difficulties. Clients accessing the ward were ‘informal’ voluntary clients or those who have been admitted under the MHA (1983). The ward had a team of medical staff, occupational therapists, nurses and nursing assistants. Clients stayed between 4-6 weeks.

Materials

Demographic information relating to the participants (e.g., age, gender, ethnicity, current job role, time (in years) working on the ward) was obtained.

The brief 21-item *Depression, Anxiety and Stress Scale* (DASS-21; Lovibond & Lovibond, 1995), a validated self-report questionnaire, designed to measure the severity of a range of symptoms common to stress, anxiety and depression, was used to provide an overview of participants’ wellbeing. Items were rated on a 4-point-Likert scale indicating the presence of a symptom over the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week).

Procedure

Participants were seen individually, provided with a copy of the participant information sheet (Appendix E) and questions about the study were answered prior to the participant providing informed consent (Appendix E). Participants completed the DASS-21 (Appendix H) and provided demographic information. An audio-recorded semi-structured repertory grid interview (Jankowicz, 2004), lasting approximately 1 hour was then completed (see Appendix G for a copy of the interview protocol). Participants were

presented with the seven elements and asked to think of clients (either current or those who had left the ward) that fitted each category element: 1) *an individual client who has a first time admission to XX Ward*, 2) *an individual client who has a second or more admission to XX Ward*, 3) *an individual client with a dual diagnosis (client with substance misuse)*, 4) *An individual client who you (i.e., staff member) find easier to care for*, 5) *an individual client who has been compulsorily detained*, 6) *a client with whom you had a difficult professional relationship* and 7) *your hypothetical ideal client*. Four further elements relating to the participant and their non-working life were included: 8) *a family friend or relative with mental health difficulties*, 9) *a person you care about/care for*, 10) *yourself (now)* and 11) *your ideal self*.

The triadic opposite method was used to generate constructs (Jankowicz, 2004). Participants were presented with three randomly selected elements and asked in what way were two similar to each other (emergent construct) and therefore different from the third. They were then asked to generate the opposite end of the construct (implicit construct), resulting in bipolar constructs. Participants described each end in detail by providing behavioural descriptions. For example, the construct ‘aggressive’ could be defined as ‘when a person was shouting loudly, swearing, pacing up and down and throwing objects’, whereas the opposite pole of ‘calm’ could be defined by ‘someone who doesn’t shout, sits relaxed and quietly, doesn’t swear at others or throw objects’. Participants were then asked to rate each element on a 5-point-scale along the construct poles that had been elicited, with the emergent construct rated as 1 and the implicit construct as 5. Those elements that had been used to elicit the construct were rated first, and the remaining elements then presented in a random order and rated along the scale. This process was repeated with random element combinations until the participant could not generate any further constructs. During a second interview, participants were presented with a visual representation (biplot) of their grid and a list of elements that were highly correlated.

Participants were asked to discuss the findings and whether the analysis was a reasonable explanation of their views (Jankowicz, 2004). At the end of the study participants received £10 as a thank you for volunteering their views and time. This procedure was agreed following consultation with the university's Community Liaison Group.

Data Analysis

Demographic data were analysed using the Statistical Package for the Social Sciences version (IBM Corp., 2013). Idiogrid version 2.4 (Grice, 2002) was used to analyse the repertory grid data, with Standardised Euclidean distances identifying which elements were most similar to and most different from each other. Elements have an expected distance of 1.00 and were considered significantly 'similar' if the inter-element Euclidean distance was less than 0.50 and significantly 'different' if greater than 1.50 (Winter, 1992). Principal Components Analysis of each repertory grid plotted the relationships between constructs and between elements (biplot) which enabled the most relevant constructs that defined each element to be identified, i.e. the element that was physically closest to the construct on the biplot. Eigenvalues, or the percentage variance accounted for by each principle component, were also calculated, with the eigenvalue for the first principal component measuring the tightness of a person's construing; the higher the eigenvalue, the less complex and more tight the construing (Winter, 1992).

Content Analysis of individual participants' constructs using the Classification System for Personal Constructs (CSPC; Feixas, Geldschläger & Neimeyer, 2002) was undertaken, with each construct being categorised in one of the seven main domains: moral, emotional, relational, personal, intellectual and operational, values and interests, and other, with each category having several subcategories.

Results

Participant characteristics

Twelve staff (two male and 10 female) (25% of a total of 48) participated and completed the repertory grid interview with 10 participants attending individual feedback sessions. Two participants were unavailable for follow-up. A sample of 12 participants is a sufficient size for a repertory grid study (Ralley et al., 2009; Blundell et al., 2012).

The average age of participants was 39.2 years (ranging from 23 to 67 years), with nursing staff having a mean of 4.8 years of experience working on the ward and nursing assistants a mean of 7.3 years of experience (with an overall range of one to 16 years). Further participant demographic information is presented in Table 1. All staff indicated that non-work related factors were the principal cause for their reported mood difficulties.

All 12 participants were able to identify individuals who fitted the client elements, eight participants provided nine constructs, one provided 12 constructs and three participants provided seven constructs but could not think of any further similarities or differences within the triads of elements.

Table 1. Staff demographic characteristics

Characteristic	Total sample (N=12) Number (%)
Staff employment type	
Staff Nurses	8 (66.7%)
Nursing Assistants	4 (33.3%)
Ethnicity	
White-British	9 (75%)
British-Chinese	1 (8.33*%)
African-Caribbean British	1 (8.33*%)
Turkish-British	1 (8.33*%)
DASS-21 score:	
Depression	
Normal	9 (75%)
Mild	1 (8.33*%)
Moderate	1 (8.33*%)
Severe	0
Extremely Severe	1 (8.33*%)
Anxiety	
Normal	11 (91.67%)
Mild	0
Moderate	1 (8.33%)
Severe	0
Extremely Severe	0
Stress	
Normal	9 (75%)
Mild	1 (8.33*%)
Moderate	1 (8.33*%)
Severe	0
Extremely Severe	1 (8.33*%)

Cognitive complexity

Principal Components Analysis was used as a measure of ‘cognitive complexity’ of the construal of clients and non-client elements. Repertory grids with no principal components are fragmented; one principal component indicates monolithic structure and two or more principal components are indicative of cognitive complexity (Bell, 2004). Additionally, if the first principal component accounts for a high percentage of the variance, an individual is using fewer dimensions to construe the behaviour of others, which is a further indication of the level of a person’s cognitive complexity (Bell, 2004).

Thus, higher levels of cognitive complexity suggest that individuals have a more varied and differentiated way of construing clients and non-client behaviour (Bieri, 1995).

Two participants (P2 & P7) were found to have less cognitively complex repertory grids with over 80% of the variance being accounted for by the first principal component (82.48% and 91.67%, respectively). In the bi-plot for P7 (Figure 1), the construct lines were close together indicating they were highly correlated. Element ratings are represented by the proximity of the elements to each construct and for grids that are less cognitively complex there is less distance between construct lines. In contrast the construing of clients by P1, P3 and P6 were very complex (i.e., both had three principal components). The remaining eight participants showed moderately complex construct systems (i.e., two principal components), also indicating differentiated construing of others. When the cognitive complexity of participants' bi-plots were taken into account, a pattern emerged which suggested that staff members whose bi-plots demonstrated less cognitive complexity tended to make a greater distinction between themselves and clients in comparison to staff members whose grids demonstrated greater cognitive complexity.

Construal of clients, non-clients and the self

Biplots were computed for each individual (see Appendix J for full participant results). Figures 1 and 2 show the biplots for P7 and P10 respectively, exemplifying the diversity of construing among individual participants in relation to clients, non-clients and the self. P7 had 12 tightly construed constructs (Eigenvalue= 91.6%), in contrast P10 had eight constructs which were more complicatedly construed (Eigenvalue = 62.12%). The elements for the client with: a) *two or more admissions to the ward*, b) *a dual diagnosis*, c) *who was compulsorily detained* and d) *with whom you had a difficult professional relationship* were construed as most dissimilar to the self by P7 (Euclidian distance = 1.45, 1.48, 1.39, 1.45 respectively) compared to P10 who only identified the client with

two or more admissions to the ward as most dissimilar to the self (Euclidean distance = 1.65) (Table 2). P7 construed *family friend or relative with mental health difficulties* as similar to a *client who you find easier to care for* (Euclidian distance = 0.30); however, P10 also construed *family friend or relative with mental health difficulties* as being similar to a client with: a *first time admission to the ward*, a *client with a dual diagnosis* and *client who was compulsorily detained* (Euclidian distance = 0.46, 0.53 & 0.46, respectively).

As can be seen in Table 2, participants rated themselves as most similar to the non-client elements of *someone you care for/care about* (Mean Euclidean Distance = .56) and the *ideal self* (Mean Euclidean Distance = .58) as well as to the *hypothetical ideal client* ((Mean Euclidean Distance = .67). Only P6 rated the non-client element *family friend or relative with mental health difficulties* as similar to themselves. Five participants (P1, P4, P5, P8 & P12) identified themselves as very or significantly similar to the client elements (excluding the hypothetical ideal client), with two participants (P1 & P4) identifying themselves as most similar to a *client who has a first time admission to the ward* (Euclidean Distance = .51 and .55 respectively). P5 identified themselves as most similar to a *client with two or more admissions to the ward* (Euclidean Distance = .56), and P8 and P12 identified themselves as most similar to the *client whom you find easier to care for* (Euclidean Distance = .46 and .52 respectively). Five participants (P2, P5, P7, P8 & P12) rated *client with whom you've had a difficult professional relationship* (Mean Euclidean Distance = 1.31) as considerably different from the self, three participants rating the element as significantly different (P2, P5 & P8). One element (*client with two or more admissions to the ward*) was seen as significantly or almost significantly different from two participants (P10 & P7 respectively). A *client with a dual diagnosis* and the *client who has been compulsorily detained* were seen as almost significantly different

from two individual participants (P7 & P12, respectively) and the *client whom you find easier to care for* was considered significantly different to the self by P2.

Table 2. Euclidian Distances for ‘Self’ to client and non-client elements

	<i>Client with first time admission</i>	<i>Client with two or more admissions</i>	<i>Client with dual diagnosis</i>	<i>Client whom you find easier to care for</i>	<i>Hypothetical ideal client</i>	<i>Client who has been compulsorily detained</i>	<i>Client with whom you’ve had a difficult professional relationship</i>	<i>Family Friend or relative with mental health difficulties</i>	<i>Someone you care for/care about</i>	<i>Ideal self</i>
<i>P1</i>	0.51	1.19	1.15	0.51	0.73	0.73	0.89	0.61	0.46	0.65
<i>P2</i>	0.93	1.16	1.29	1.54	0.91	1.21	1.74	0.62	0.23	0.23
<i>P3</i>	1.05	0.91	0.86	0.83	0.68	1.03	1.27	0.8	1.03	0.8
<i>P4</i>	0.55	1.25	1.11	1.1	0.81	1.26	1.24	1.15	0.25	0.46
<i>P5</i>	0.66	0.56	1.05	0.77	0.4	0.63	1.87	0.72	0.35	0.35
<i>P6</i>	0.85	1.09	0.88	1.14	1.03	0.98	0.92	0.45	1.03	0.32
<i>P7</i>	1.22	1.45	1.48	0.82	0.3	1.39	1.45	0.66	0.45	0.42
<i>P8</i>	1.02	0.61	0.93	0.46	0.46	1.22	1.51	0.72	0.25	0.43
<i>P9</i>	1.04	0.65	0.62	1.13	1.08	1.06	0.92	0.81	1.09	0.88
<i>P10</i>	0.59	1.65	0.75	1.02	0.53	0.59	1.27	0.75	0.59	0.91
<i>P11</i>	0.93	0.91	1.38	0.93	0.65	0.83	1.29	0.78	0.55	1.07
<i>P12</i>	0.58	0.74	0.9	0.52	0.52	1.45	1.42	0.94	0.45	0.45
<i>Mean Euclidian distance</i>	0.82	1.01	1.03	0.89	0.67	1.03	1.31	0.75	0.56	0.58

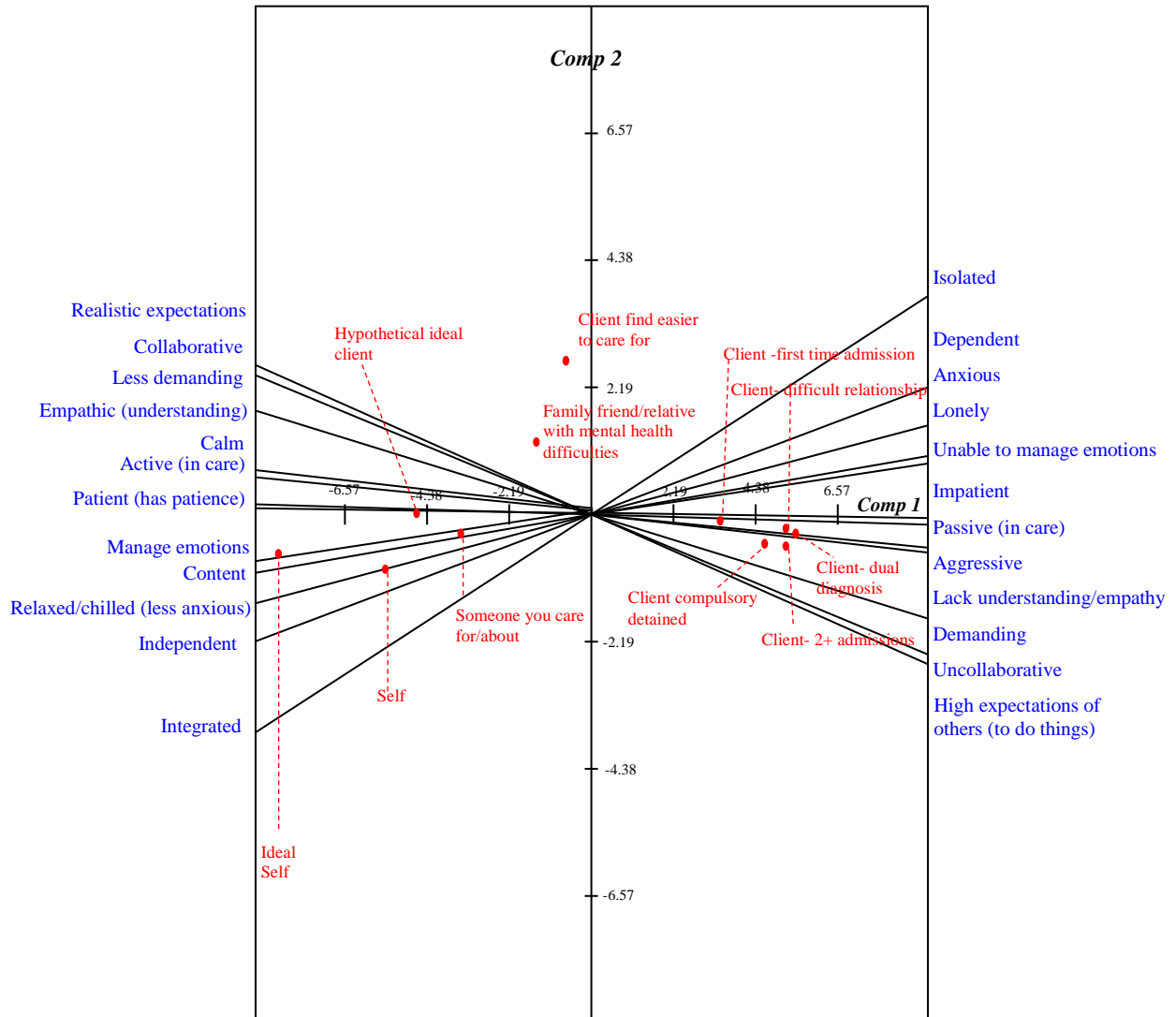


Figure 1. Participant 7 bi-plot

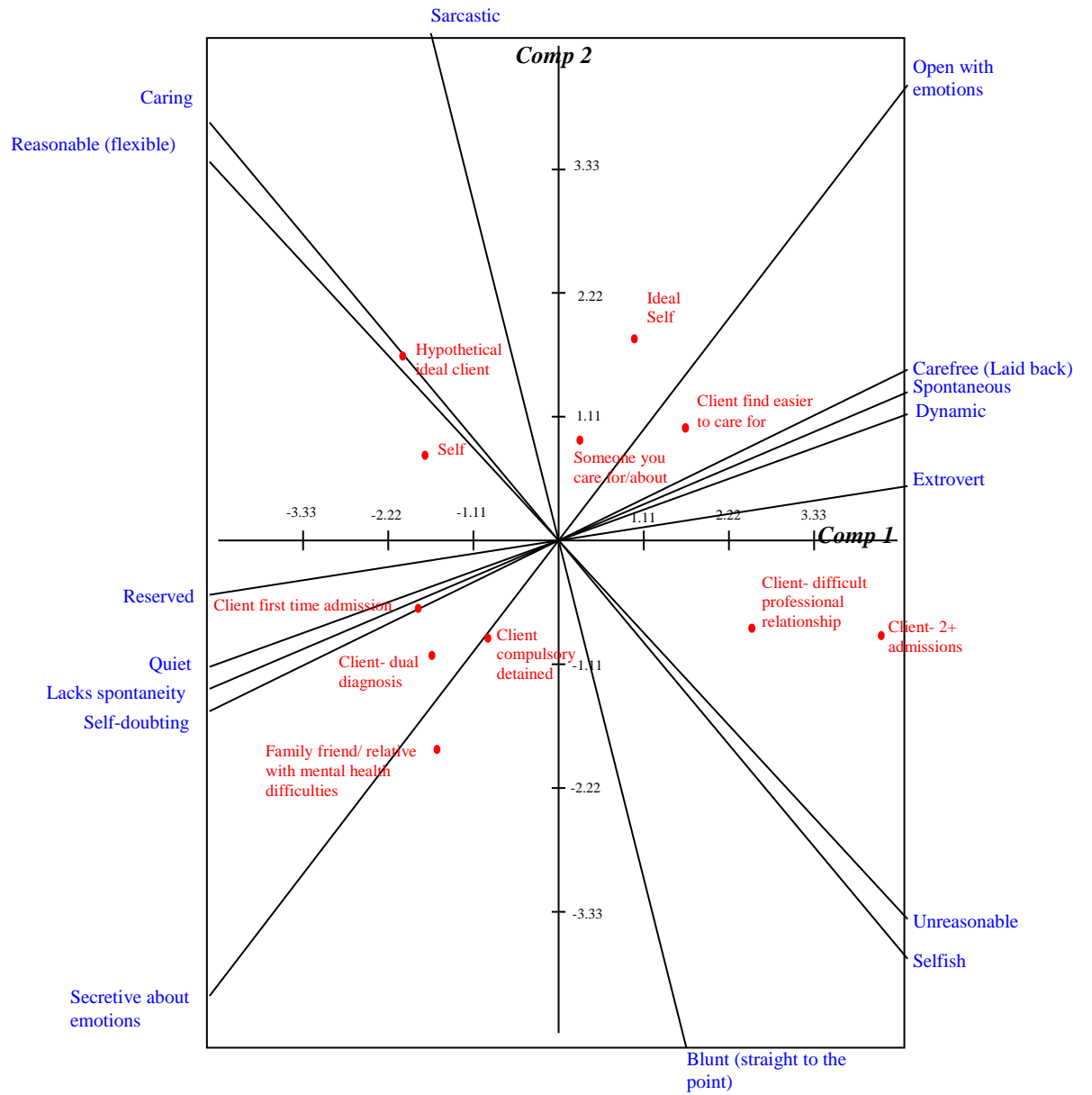


Figure 2. Participant 10 bi-plot

Relationship between construal of the individual client elements

Client who has a first time admission to the ward. From the individual grids it was clear that staff construal of clients who have a first time admission to the ward was varied. However, P2 and P7 construed them in a more negative way, highlighting that they were closest to the constructs of “not thinking rationally”, “being impulsive”, “self-centred”, “impatient”, “passive” and “aggressive”⁵. This was in contrast to other participants, who viewed this client group as significantly similar to other client groups; *client who find easier to care for* and *hypothetical ideal client* and well as similar to the non-client elements, in particular to a *family friend or relative with mental health difficulties*. Content analysis using the CSPC (Feixas et al., 2002) revealed constructs relating to this client group included moral values, in particular staff construed this client group as being concerned about others (‘altruist’⁶) and ‘sincere’, as well as describing clients as emotionally ‘warm’. Staff also construed the relational style of clients with first time admission as more ‘introverted’ and, ‘peaceable’, as well as being more ‘conformist’ in relation to suggestions and support.

Client with two or more admissions to the ward. Staff construal of clients with two or more admissions to the ward was also varied; however, only P11 viewed this group of clients as similar to their *hypothetical ideal client* or *client with whom they found easier to care for*. Two participants (P1 & P10) identified that they were significantly different from these client groups. Three staff (P9, P11 & P12) identified this client group as significantly similar to a *family friend or relative with mental health difficulties*. Although construed in a varied way by staff, content analysis (Feixas et al., 2002) revealed that for this client group participants identified constructs that can be identified within the

⁵ Elicited constructs/ quotes by participants are identified in quotation marks.

⁶ Category descriptions derived from the CSPC are identified in inverted commas.

category ‘rigid’ which relates to their personal way of being as well as the categories ‘rebel’ and ‘aggressive’ describing their styles of relating to others. Constructs can be identified within the ‘moral’ category of the CSPC which is concerned with the moral value of the person or element, and is based on a judgement around the person’s moral character (e.g., good, altruistic, proud). Some participants viewed clients with two or more admissions as ‘insincere’.

Client with dual diagnosis. All participants construed the *client with a dual diagnosis* towards the negative end of the pole, with the element being aligned with moral constructs relating to only thinking of oneself (‘egoist’) and being untrustworthy (‘insincere’). Relationally clients with a dual diagnosis were construed as ‘aggressive’ and ‘unsympathetic’. Additionally, using the categories identified by the CSPC some participant constructs relating to the area of personality and way of being identified this group of clients as ‘lazy’ but also unsure of self/insecure (‘self-criticism’). *Clients with a dual diagnosis* were construed as most similar to *clients who were compulsorily detained* and those with whom staff had a *difficult professional relationship*, with four participants identifying significant similarities between these elements (P7, P9, P10 & P11). Although only one participant viewed *clients with a dual diagnosis* as distinct from themselves (P7), the data suggest that participants did construe themselves and non-client elements of *someone care for/care about* in a different way to this client group, but less different from a *family friend or relative with mental health difficulties*. Only P9 viewed this client group to be significantly similar to a *friend/relative with mental health difficulties*.

Client whom you find easier to care for and hypothetical ideal client. The elements a *client who you find easier to care for* and *hypothetical ideal client* were considered to be most similar to the self and to the non-client element of *someone you*

care for/care about, with four participants (P1, P8, P10, P12) construing either one or both of these as significantly similar to the client whom it is easier to care for. Seven participants (P5, P7, P8, P9, P10, P11 & P12) also construed either one or both of these elements as similar to the *hypothetical ideal client* element. Three participants (P5, P8 & P12) identified the *client who you find easier to care for* and the *hypothetical ideal client* as significantly different from the *client with whom you have a difficult professional relationship*. Additionally the *hypothetical ideal client* was construed as significantly different from the client who has been compulsory detained (P8, P9 & P12). Only P2 identified the *client who you find easier to care for* as significantly different from the self and *someone you care for/care about* and most similar to *client with whom you have a difficult professional relationship* and a *client with a dual diagnosis*. P2 explained that: “these clients engage in the same behaviours on the ward but this client [*client you find easier to care for*] it is due to their mental health difficulties and so can’t help it, whereas this person [*client with whom had difficult relationship*] it’s who they are.”

Content analysis revealed that these two client groups were mainly aligned to personal qualities of being ‘hard working’, ‘flexible’, as well as having a relational style that was ‘peaceable’ and ‘independent’, and were considerate of others (‘altruist’).

Client who has been compulsorily detained and client with whom you’ve had a difficult professional relationship. Clients who have been compulsorily detained and those with whom staff had a difficult professional relationship with were considered to be most similar with four participants (P6, P7, P8 & P9), identifying significant similarities between these client groups. Only P5 identified a significant difference between these clients. Two participants (P5 & P10) identified that clients who had been compulsorily detained were significantly similar to non-client elements of a *family friend or relative with mental health difficulties*, *someone you care for/care about* and the *self*;

however, no participants identified any similarities between non-client elements and the *client with whom you've had a difficult professional relationship*. Eight participants identified significant differences between either all or some of the non-client elements and the *client with whom you've had a difficult professional relationship*, with P5 identifying the most significant differences. Least differences were construed between a *family friend or relative with mental health difficulties* and this client group. Content analysis revealed that both client groups were construed towards the negative end of constructs with participants providing constructs that related to relational styles that were categorised as 'rebel' and 'aggressive'. Furthermore, constructs were categorised as 'visceral' in regards to their emotional attitude towards life, suggesting that participants saw clients as 'impulsive', 'emotional' and 'reactive or quick to temper'. In terms of moral judgements made about these two client groups, participants identified constructs under the category 'egoist' which indicated these client groups tended to think more about themselves than others. Some differences were observed with some participants construing a *client who had been compulsorily detained* as more 'dependent' and 'introverted' in their relational style.

Differences between participant demographics and construal of clients

Staff nurses and nursing assistants. Independent samples Mann-Whitney U test revealed no significant difference between Euclidian distances for employment type (staff nurses and nursing assistants) and any of the client and non-client elements ($(Mdn = 8.93)$, $U = 22.0$, $z = 1.02$, $p = .368$, $r = .29$), suggesting that both staff nurses and nursing assistants construed the self to clients and non-clients in the same way. Although no significant difference was found between the two groups, visual scrutiny of the Euclidian distances suggested that in this group staff nurses viewed themselves to be more similar to *clients with two or more admissions to the ward* than nursing assistants (mean

Euclidian distance = 0.89 and 1.25 respectively). Both staff nurses and nursing assistants construed the *hypothetical ideal client* as most similar to themselves (mean Euclidian distance = 0.67 and 0.68 respectively) and *client with whom had a difficult professional relationship* as most different from the self (mean Euclidian distance = 1.36 and 1.22).

Gender, years working on ward and age of participants. Only two of the 13 male ward staff participated in the study. Following visual scrutiny of the Euclidean distances, the two male staff members appeared to construe *clients with two or more admissions to the ward* and *clients with a dual diagnosis* as more similar to themselves than female participants.

It was not possible to compare staff constructs based on age or years working on the ward given that the groups were heavily weighted by employment type.

Content analysis

Of the 103 constructs elicited, the majority were 'relational' (n= 42), and the remaining constructs mostly related to 'moral' (n=23) or 'personal' (n=20) with a further 13 in the 'emotional' category (Appendix K). The 'intellectual and operational' category, which could be seen to refer to skills, abilities and knowledge, contained only four constructs, and referred to the client's ability to understand their difficulties *per se* (i.e., their level of insight). The final category 'existential' was a supplemental category representing an individual's core sense of self or life. Only one construct was identified in this category. The individuality of construing was apparent during the content analysis. For example, a number of participants used the word "caring" to describe the positive end of a construct to describe someone who was not demanding and who was thoughtful around the demand for staff and them not being able to meet their needs immediately, others used the construct "accepting" or "patient", to describe similar moral attributes. This highlights that the detailed descriptions of the

constructs were important, because individual words held different meanings for each participant.

Discussion

The present study explored the personal meanings that staff members attached to their subjective experiences of working with clients on an acute inpatient ward. The findings highlight a) that few staff members construed clients in a similar manner to their construal of themselves and b) differences between the construal of different client groups, with clients with first time admission to the ward being construed more positively than other client groups.

Fewer than half of participants construed clients (excluding hypothetical ideal client) as similar to themselves, with only those participants whose grids showed greater cognitive complexity indicating less distinction between the construal of the clients, themselves and non-clients. Those clients with more complex presentations, in particular those who were admitted to the ward on two or more occasions and those with whom staff had a difficult professional relationship were construed as most dissimilar to the self. Previous research has also noted that staff expressed increased negative attitudes and less empathy towards clients with a diagnosis of borderline personality compared to those with a diagnosis of major depressive disorder or generalised anxiety disorder (Bodner, Cohen-Fride, Mashiah, Segal, Grinshpoon, Fischel & Iancu, 2015). Blundell and colleagues (2012) reported that mothers with psychosis or personality disorder were construed towards the negative end of the pole and that attributions about the clients' behaviour as well as the clients' interactional style negatively influencing the ability of staff members to develop positive relationships. In the current study, the interactional styles of clients with more complex difficulties were generally perceived to be more demanding and aggressive. According to Kelly (1955), an individual's processes were

informed by their experiences: as new situations, knowledge and experiences were encountered an individual develops their construct system, allowing them to anticipate new events. Thus, there is the risk that for clients who are considered to have more complex needs, in particular those who have two or more admissions to the ward, anticipatory constructs around this client group's interactional style may mean their behaviours are automatically construed as demanding and aggressive, perhaps at the expense of understanding individual behaviour or needs.

Limitations

Although providing rich data, the idiographic nature of the study led to some limitations. A quarter of staff members (12 out of 48) participated and were a self-selected sample of staff. Whilst the participant sample was representative of the staff population in terms of age and years working on the ward, it was not representative of the employment type or gender, with only four nursing assistants participating and only two men taking part in the study. As the findings suggest that the two male staff members construed clients somewhat differently, it would have been beneficial to see if this was representative on a wider scale. Additionally, the degree to which the findings are a function of group membership or individuality is difficult to assess (Rawlinson, 1995).

A further limitation is that staff members were free to select any individuals who they felt matched the provided elements. As a result it is likely that staff members selected different individuals to represent the same element. Furthermore, for the element of a *family friend or relative with mental health difficulties* it was apparent during the interview that there was significant variation in the degree of mental health difficulties of the individuals selected for this element. Staff were not explicitly asked to identify what difficulties this person experienced. If participants thought of individuals with less

complex difficulties, this may account for differences in construal between clients and family friend/relative with mental health difficulties.

Current research highlights that those experiencing mental health difficulties can experience stigma and discrimination (WHO, 2013), therefore given that the present study explored nursing staff attitudes towards adults on an acute psychiatric inpatient ward, it must be noted that participants may have been influenced by social pressures to respond as they should and not as they actually believe. As with other modes of enquiry, there is no guarantee that an individual will share their actual belief system (Jankowicz, 2004). Furthermore, as the repertory grid technique represents a person's subjective understanding of the world, if a person's construing is influenced by what they perceive to be 'group norms', whether consciously or non-coconsciously, this informs part of their construing at that point in time. Thus, in line with Kelly's (1955) notion that people are changing beings, their attitudes towards certain elements may also change and therefore consistence of an individual's construal system may be low (Gathercole, Bromley, & Ashcroft, 1970; Björklund, 2008).

Jankowicz (2004) suggests that it is necessary to accept social desirability and work with it; however, it is possible to identify the extent to which some constructs (values) are affected by social desirability. He identifies that by asking individuals to choose their preference between constructs of roughly equal social desirability, it is possible to identify an individual's preference, over other constructs, independent of their social desirability. This can be done utilising the resistance-to-change technique which helps individuals identify personal values with precision, lessening the possibility of bias due to social desirability responding (see Jankowicz, 2004, for detailed discussion).

Clinical implications

Given the impact of unconscious (implicit) bias, which exists within health systems such as the NHS (Kapur, 2015), this finding is relevant to clinical practice. Recent studies have highlighted that healthcare workers do not provide equal levels of care to patients of different social groups as a result of unconscious biases (Clark, 2009) despite national policies that endorse equality. Furthermore, implicit biases can impact upon clinical decision making amongst mental health workers (Brener, Rose, von Hippel & Wilson, 2013). This is important when working within an inpatient ward environment, where information about a person's past medical history, admissions and experiences on the ward will be discussed both formally and informally. Thus, there is the risk that unconscious biases and constructs about an individual client may be developed based on information shared by staff members. According to Edwards (2011), new staff members can feel stifled by ward culture in particular around negative stereotypes attached to service users with conditions such as personality disorders. For staff who have past experiences of individuals there is also the risk that negative evaluations of individuals based upon prior interactions will reduce the potential of optimum care when clients return to the ward. Thus supporting staff to formulate and understand an individual's distress, behaviour and needs may help staff to focus away from anticipated constructs and biases. In the current study some participants expressed that having the time to identify similarities between clients was helpful, because it was something they had not previously done, it allowed them to think of clients whom they had originally perceived in a particular way, and consider them in a different manner. Additionally, following the feedback of the pingrids, one participant identified that the process had enabled them to consider how they worked with clients, in particular they reflected on how they could ensure there was not as great a distance between themselves and the client whom they had a difficult professional relationship with.

Compassionate care from nursing staff has been aligned with actions which can often take time as well as fleeting actions (Bramley & Matiti, 2014); however, it has been highlighted that the administrative duties required in nursing impacted on the time staff were able to spend with clients, in particular staff reported that these duties were the dominant culture on the wards and was seen as having greater importance than valuing human contact (Edwards, 2011). Edwards (2011) also highlighted that some nurses saw their role as patient management and containment, especially as the focus on risk is now central in the provision of mental health care (Muir-Cochrane et al., 2011). Staff constraints on time and competing demands to support clients and undertake other duties was discussed by participants with staff construing some clients who wanted immediate support (in no risk situations) as demanding or selfish.

In the current study staff described the context under which their perceptions were reached, with all staff describing personal experiences they had faced on the ward. Staff described challenging situations they had been placed in by clients, especially when clients were hostile or aggressive. The NHS constitution (2013) identifies that staff themselves should receive compassion as well as clients, therefore in situations when staff experience aggression it is understandable that cognitive and emotional reactions are elicited. It is therefore important for staff to have support mechanisms to manage such stressful situations, especially given that individuals are more prone to socially biased decisions and behaviours when highly stressed or tired, and when decisions need to be made quickly (Moskowitz, 2010). Support mechanisms, such as clinical supervision with a trained professional, where staff can voice and explore difficult reactions towards clients in order to contain anxieties and prevent further stress (Flood, Brennan, Bowers, Hamilton, Lipang, & Oladapo, 2006) are important. In the current study staff found exploring their views about clients insightful, with some staff reflecting on how they supported individuals. Providing staff with opportunities to access therapeutic support

through programmes such as mindfulness has also been found to reduce burnout (Goodman & Schorling, 2012) as well as reducing stigmatizing attitudes (Hayes et al., 2004.)

Further research

Previous research used repertory grid technique to explore clients' perspectives of nursing staff and compassionate care highlighting that clients found staff who were flexible in their approach to be more supportive which facilitated recovery (Gillham, Hare & Wittkowski, under review). Understanding how clients admitted to larger wards construe staff should identify if staff resources impact on the relationship between compassion experiences and recovery. Future research could also explore if there are differences in the construal of clients between acute inpatient ward staff and community mental health nurses. Staff working in these areas hold more positive attitudes towards clients because they are most likely to see service users recover and return to independent living compared to staff who work within residential settings (Mårtensson, Jacobsson & Engström 2014).

Conclusions

In this study, nursing staff whose grids showed greater cognitive complexity demonstrated more perceived similarities between themselves and their clients admitted to an acute inpatient ward. Yet clients with more complex presentations were considered to be most different from the self by all staff members. These results underline the importance of nursing staff having support mechanisms, including clinical supervision with a trained professional for staff to voice difficult reactions towards clients in order to contain anxieties and to formulate and understand an individual's distress, behaviour and

needs. This will not only improve the well-being of staff but ultimately contribute to improved care for service users.

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Paper 3: Critical Reflections Paper

Critical reflections on the systematic review and empirical research

Word count: 5528 for complete paper, 4615 for main text.

This paper presents a critical appraisal of the research presented in this thesis. The appraisal will reflect and evaluate the process of completing the systematic review and the empirical paper, respectively. The strengths and limitations of this research will be explored as well as pertinent issues identified by the researcher.

Paper 1: Systematic review

The topic

In developing a review question the aims were guided by the empirical study and therefore the initial focus was upon the attitudes of mental health nursing staff working within acute or rehabilitation settings. The author hoped the review would provide some context for Paper 2. A number of reviews relating to mental health professionals' attitudes towards individuals with mental health difficulties were identified in the initial scoping of the literature. However, it became apparent that these reviews focused on mental health professionals as a group and did not separate findings in relation to profession (Schulz, 2007; Wahl & Aroesty-Cohen, 2010). One review exploring only nurses' attitudes focused on the role of nurses as 'stigmatisers' or 'stigmatised' (Ross & Goldner, 2009). A further exploration of the literature regarding mental health nurses' attitudes was clearly needed; however as a large number of qualitative and quantitative studies have been conducted in this area (see PRISMA diagram Paper 1), it was necessary to limit the scope of the review. Given that nurses are the largest group of health care professionals within Europe (WHO, 2007) and are often the front-line staff who work with individuals experiencing mental health difficulties, it was identified that reviewing the literature on European mental health nurses' attitudes towards individuals with mental health difficulties was a pertinent topic.

The search process

Based upon scoping exercises prior to the systematic review a list of search terms was devised to ensure that all studies were captured. For example, from an initial sweep of the literature it was noted that some papers included assessments of other mental health professionals as well as nurses' attitudes; however, papers varied in how they reported the findings, with some reporting the group as a whole and some separating professions. It was therefore considered appropriate to include the search term "mental health professionals" or "mental health staff" to ensure relevant papers were not missed. Furthermore, it became apparent that the search terms were also yielding papers conducted in other countries, but it was difficult to limit the electronic database search to only those studies undertaken in Europe. It was therefore decided that studies that met the inclusion criteria, i.e., countries identified as a member state of the WHO European Region (2013) would be identified by hand once all relevant studies were collated.

During the preliminary scoping searches it was recognised that self-report questionnaires with or without case vignettes were the predominant methodology used to explore staff attitudes. Thus, the review aimed to explore only studies that used cross-sectional questionnaire designs and consequently qualitative or mixed method designs were excluded. In identifying the years in which articles were searched, it was decided that although anti-stigma campaigns within Europe have been initiated since the late 1990s, a number have been implemented since 2007 (Borschmann, Greenberg, Jones & Henderson, 2014), including the *Time to Change* anti-stigma campaign in England. Hence, a search of the literature from 2007 to March 2016 was conducted, because studies prior to 2007 might have reported dated attitudes, therefore not reflecting nursing staff's attitudes.

Quality assessment measure

When conducting a systematic review, included articles should be assessed for methodological quality using validated tools that enable the critical appraisal of findings (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012). After a detailed search and exploration of a recent article that reviewed quality assessment tools (Jarde, Losilla, & Vives, 2012), it became obvious that there was a lack of assessment tools that also provided a quality rating scale for cross-sectional studies. The use of the STROBE (von Elm, Altman, Egger, Pocock, Gøtzsche & Vandenbroucke, 2007) was explored but it comprised a checklist and no rating scale. It was therefore decided that the Effective Public Health Practice Project tool (EPHPP) offered the necessary rating scale and also provided the flexibility required to adapt it to meet the needs of the review. Moreover, the EPHPP has good content and construct validity (Thomas, Ciliska, Dobbins & Micucci, 2004) and inter-rater reliability (Armijo-Olivo et al., 2012). To ensure there was no bias in the quality assessment ratings, 50% of studies were rated by an independent rater. A good degree of reliability was obtained ($k = .74$). The difference in rating was due to one rater rating methodological quality as slightly higher, based upon the assumption that in studies that included other professionals in addition to nursing staff the rater took the overall percentage of participants that took part rather than the percentage identified for nursing staff only. This discrepancy was resolved through discussion.

Analysis

Although all of the included papers were cross-sectional questionnaire studies, eight papers were rated as 'weak', which was in part due to the relatively low percentage of individuals agreeing to take part in the individual studies. Furthermore, papers used a variety of questionnaires (eight in total), with four studies using questionnaires where no

information regarding validity or reliability was available and a further two studies only reporting reliability of the questionnaires used. This is a source of bias as the varying nature of these questionnaires means that there are substantial gaps in what they assess (Mehta et al., 2015). Although they provide further insight into the attitudes of nursing staff towards those with mental health difficulties and are consistent with other reviews in this area, the results of the current review are limited by the absence of high quality papers and so should be treated with some caution. This review also decided not to include interview or mixed method papers. As identified in Paper 1 including these studies might have enriched the review and provided a better understanding of the mechanisms underlying nursing staff attitudes; however, only five studies would have met the inclusion criteria.

Another aspect that needs to be considered is that the author lacked the resources to include non-English language papers and consequently these papers were discounted. This may also have led to a bias in the papers selected. The WHO has identified disparities in the quantity of mental health research between high and low to middle-income countries (Sharan, Levav, Olifson, de Francisco, & Saxena, 2007); however, the disparity in the quantity of studies within Europe may be accounted for by the fact that in the UK there is one of the world's leading mental health research institutions, The National Institute of Mental Health, which promotes the importance of research within this area in order to improve mental health standards.

Conclusions

This systematic review into the attitudes of European nursing staff found that overall attitudes varied with inconsistencies in demographic factors associated with these attitudes. Two studies identified that personal experience of mental illness through friends/family members did result in more positive attitudes. Whilst this review was able

to make a number of recommendations regarding clinical practice, further research into the mechanisms that underlie nursing staff attitudes is clearly required.

Paper 2: Empirical Paper

The topic

This thesis focused upon the concept of understanding nursing staff's construal of adults admitted voluntarily or under the Mental Health Act (1983) to an inpatient psychiatric ward.

In 2014/15, 58,399 people in England were detained in National Health Service (NHS) hospitals (HSCIC, 2015), with those experiencing severe mental health difficulties being supported by crisis and acute NHS inpatient services (Mind, 2012). Research has shown that those experiencing mental health difficulties can face stigma and discrimination (Henderson & Thornicroft, 2009), which in the past was perpetuated by the negative media portrayal of people experiencing mental illness as being violent, dangerous and demonstrating bizarre behaviour (Hindshaw & Steir, 2008). However, since the early 2000s media coverage of mental illness has become less stigmatising (Goulden, Corker, Evans-Lacko, Rose, Thornicroft & Henderson, 2011) and national anti-stigma campaigns introduced. Following the launch of *Time to Change* in England in 2007 the evidence suggests that there has been a reduction in public discrimination over recent years (Evans-Lacko, Corker, Williams, Henderson & Thornicroft, 2014).

In line with the continued campaigns and in order to reduce stigma and discrimination in the NHS, the introduction of the Compassion in Care 6C initiative (Cummings, 2012) and the endorsement of compassion towards both service users and staff within the NHS Constitution (NHS, 2013) were outlined. Despite these initiatives, the level of stigma and discrimination experienced by individuals within the NHS has

been reported to have remained the same (Henderson et al., 2014). Given that positive therapeutic relationships have been found to be one of the best-known predictors of favourable outcomes of therapy (Norcross, 2011), and that stigma and discrimination can act as a barrier to an individual's recovery and the development and delivery of effective care and treatment, (Hansson, Jormfeldt, Svedberg & Svensson, 2011) understanding the attitudes of those who work closely with people experiencing mental health difficulties is paramount.

Clinically, the author has friends and family who have accessed support from acute inpatient psychiatric services, although the author has only worked within Primary Care Mental Health Services and in those services the author has known individuals who have worked within acute mental health and rehabilitation services. These experiences made the author curious regarding staff attitudes about the individuals they support. The findings of Paper 1 indicate that whilst nursing staff hold varied attitudes towards those with mental health difficulties, the predominant method used to assess attitudes through the use of questionnaires with or without case vignettes has limitations. Specifically, questionnaires can be influenced by social desirability bias and do not allow people to talk about real life experiences. Hence the use of other methodologies that reduce social desirability responses, such as the repertory grid technique (Jankowicz, 2004) may elicit more personal, relevant and meaningful views/attitudes.

The methodology

Reasons for selection of repertory grids. The Repertory Grid technique was selected for a number of reasons. Repertory grids are now a widely used method to explore staff views and attitudes of particular groups of individuals, including those with a diagnosis of anorexia nervosa (Woodrow, Fox & Hare, 2012), individuals with an intellectual disability with challenging behaviour (Hare, Durand, Hendy & Wittkowski,

2012), and pregnant women with a BMI of greater than or equal to 30kg/m² (Hodgkinson, Smith, Hare & Wittkowski, 2016). Use of this method also adds to the existing knowledge base regarding nursing staff construals of individuals experiencing mental health difficulties (Ralley, Allott, Hare & Wittkowski, 2009; Blundell, Wittkowski, Wieck & Hare, 2011).

The use of the repertory grid technique was a new research methodology to the author that enabled exploration of individuals' attitudes through the use of their own words and narrative. Repertory grid interviews are based upon Personal Construct Theory (PCT, Kelly, 1955), which postulates that individuals construct their own understanding of the world based on their own unique experiences. This understanding and knowledge is then used to predict and explain the behaviour of others and the self. Unlike other research methods, PCT does not assume anything about the nature of an individual's experience, but is explored collaboratively using the participant's own words and language. The only meaning imposed upon the participants in Paper 2 was the elements used; aside from these, the rest of the focus and content of the research was driven individually by each participant. Through the interview discussion it appeared that participants gained some understanding of themselves and how they relate to those they supported, or had their understanding reinforced. Participants were offered the opportunity to review their grid and had the opportunity to discuss their thoughts and how this related to the way they worked. As noted in Paper 2 participants found this insightful and it also provoked some thoughts around how participants could change the way they worked with individuals they supported. This direct personal benefit was rewarding for the author and provided motivation to persevere with recruitment.

In relation to the elements used in Paper 2, through discussion within the research team the elements were chosen based on a combination of advisory repertory grid literature (Jankowicz, 2004) and on literature about staff attitudes towards those with

mental health difficulties. The element *'ideal self'* represented the participant's view of ideal qualities and demonstrated how close to or far away from those qualities the participant viewed clients as being. The *'hypothetical ideal client'* element ensured that it was possible to explore how staff members construe their ideal client compared to 'real' clients they work/have worked with. The different client elements were also chosen to identify whether staff differentially construed individual client groups (e.g., some with a dual diagnosis, someone with two or more admissions, someone compulsorily admitted to the ward). The elements a *'family friend or relative with mental health difficulties'* and *'a person you care about/care for'* were included to explore how staff viewed clients in comparison to those they care for in a non-working environment, who either did or did not experience mental health difficulties. It was felt these elements would provide a varied group of individuals and would therefore allow participants to think of rich constructs that they associated with the individuals who represented each element.

Limitations of repertory grids. Although there are many benefits of the repertory grid technique, this method did have limitations. As discussed in the limitations section in Paper 2, staff members were free to select any individuals who they felt matched the provided elements. As a result it is likely that staff members selected different individuals to represent the same element. For the element a *'family friend or relative with mental health difficulties'* it was apparent during the interview that there was significant variation in the degree of mental health difficulties of the individuals selected for this element. This is the disadvantage of an approach that explores each person's unique perspective; whilst allowing for a clear understanding from each individual, the identification of commonalities and overlaps amongst the group are therefore more complex. Furthermore it was also apparent that there were differences between whether the individuals selected for the element *'a person you care for or care about'* were children or adults. For individuals who had chosen children for this element (this was apparent

through their discussion), there was a sense that some of the construals, such as demanding or dependant, were more acceptable given their life stage, as opposed to adults who were viewed in this way. The inclusion of non-client elements aimed to explore how individuals construed clients they supported on the ward compared to those they cared for outside of the ward environment; however, perhaps it is not surprising that staff construed client elements as different from the self and non-client elements. Research has suggested that whilst compassion is innate, it has been defined as an “other-orientated state” (p.351) which is likely to be most intense towards the suffering of others who are self-relevant, such as offspring, relatives, partners and friends (Goetz, Keltner & Simon-Thomas, 2010). This may explain why some participants perceived a *family friend or relative with mental health difficulties* as more similar to the self than to the client elements. Additionally, it may also explain why some research has shown that those with personal experiences through friends/family with mental health difficulties hold more positive attitudes. If individuals can see similarities between the individuals they support and family/friends with mental health difficulties they may demonstrate more compassion. Upon reflection, alternative non-client elements, such as a *staff member/colleague who you get on well with, staff member/colleague who you dislike/found difficult to work with, your ideal staff nurse/nursing assistant*, might have elicited constructs that are associated with behaviours and characteristics associated with nursing qualities as well as possibly enabling greater exploration of concepts associated with compassionate care. This may be a focus for future research.

Knowledge of repertory grids. Prior to this research thesis the author had never utilised the Repertory Grid technique and was not familiar with the underlying theory. Through additional reading and discussions with supervisors and previous trainees who had used the technique an understanding of the theory was developed. Before beginning the research the author discussed the interview process and practiced this with a previous

trainee who has utilised the technique. The analysis was more challenging due to a lack of manuals or books providing a guide for the analysis package Idiogrid version 2.4 (Grice, 2002), but the author was able to familiarise herself with the analysis package to complete the appropriate analysis. Following the research process the author has become aware of how the repertory grid technique can be used both within a research capacity but also in clinical practice. Having completed the study, the author feels confident applying the technique in both these areas.

Recruitment. Previous research has highlighted that nursing staff working on inpatient wards can be very busy and resources can be limited or stretched (Edwards, 2011). Thus, it was important to consider staff availability and the impact individuals participating would have on staff resources as well as clients on the ward, in addition to ensuring participants did not spend their break times completing the research. Through a discussion with the Ward Manager, it was agreed that recruitment and interviews at the weekend would allow more time and flexibility for staff to participate as the ward environment was generally quieter. It was identified that staff were on rotated shifts, thus, staff working at the weekend also worked during the week and so the participant pool was not limited to staff members who only worked weekend shifts.

The ward staff were very motivated to support the recruitment, information posters and PIS were made available in the offices and staff room and prior to the author arriving on the ward, staff had been asked if they wished to participate and given time in their shift to do so. During the interview process being flexible was essential. A benefit of the repertory grid technique is that it can be stopped and resumed at a later time. This was necessary on one occasion when the staff member was required to pause the interview whilst they helped to support other staff members.

Sample. A total of 12 participants out of 48 were recruited. As repertory grid is based on idiographic mode of enquiry, 25% of the possible participant pool is a good

sample size and is similar to previous studies (Ralley et al., 2009; Woodrow et al., 2012). A total of 36 members of staff working on the ward did not take part in the study, due to either difficulties with finding the time to participate, not wishing to partake or not meeting the criteria (i.e., having worked on the ward for less than a year [nursing assistants N=3]). Of those who did not participate, ages ranged from 23 to 67 years, with staff having worked on the ward between less than one year to 16 years. Twelve staff nurses (one male and 11 female) and 24 nursing assistants (10 male and 14 female) participated, all of whom had worked on the ward for more than one year. Staff ethnicity of those who did not participate was diverse with staff of Black-British, Other European, African-Caribbean and Asian, although the majority of staff were White-British. As noted in the limitations of Paper 2 the sample of participants was not representative based on gender or employment type. Although it would have been ideal to recruit a more representative sample, participation was voluntary and based on those willing and able to participate at the time. Staffing shortages and time restrictions were a difficulty on the ward, which impacted upon possible recruitment of more nursing assistants and male nursing staff.

Analysis

The repertory grid technique provides a rich amount of data that can be analysed in a variety of ways, either as individual grids or analysed altogether as a group. Analysis can also be quantitative or qualitative or both. Given the purpose of this study was to explore the concept of nursing staff's attitudes, it was considered that some qualitative analysis was also beneficial. Two possible qualitative analysis options were available: either bootstrapping novel categories or using a standard category scheme (see Jankowicz, 2005, for further discussion). The author decided to use the Classification System for Personal Constructs (CSPC: Feixas, Geldschläger, & Neimeyer, 2002) because it has

been previously used in Repertory Grid studies (e.g., Gillham, Hare & Wittkowski, under review). Furthermore, the level of reliability using this system compared to bootstrapping is comparable and the use of a standard system enables comparisons with other findings if desired. Applying the framework outlined by Feixas et al. (2002) to the elicited constructs was relatively straight forward. It was necessary to use each person's individual description of the elicited constructs (i.e., the behavioural descriptors) to help define what the construct described. In this sense the qualitative analysis was informative to consider how individuals' constructs were similar or represented even if the same word (construct) was used.

One dilemma of the analysis was how far to synthesise the data because repertory grids produce a rich amount of individual data and undertaking group analysis loses this but allows for commonalities to be explored. Finding this balance was challenging; however, it was decided that clinically it would be more relevant and interesting to explore individualities, hence group analysis was not undertaken but individual grids were compared to obtain an understanding of nursing staff's attitudes as a whole.

Challenges of conducting the research

A consideration the author faced prior to the interviewing process was whether or not to ask participants to rate which end of the pair of constructs was the preferred pole. The author decided against this because she believed that it might invite a level of social desirability bias given that participants were rating clients and non-client elements along the rating scale.

Endorsed by the Community Liaison Group, they were offered a voucher in order to thank participants for their time in participating; however, before the study commenced the author considered whether participants would prefer a voucher or the value in monetary form. Following discussion with the Ward Manager, it was felt that the

monetary value would be preferential and so a minor amendment to UREC ethics was submitted and approved.

As outlined previously a challenge in conducting the research was the availability of staff to participate. The author had to be flexible during interviews and when they took place. An advantage of the ward environment (open 24/7) was that it facilitated recruitment, enabling the author to attend the ward at weekends, which the author was happy to do, especially as staff had indicated their interest in the study and that recruiting at the weekend would be more helpful to the staff team. Finally, the repertory grid interview relies upon an individual's idiosyncratic language and requires participants to think of constructs and to describe these. Although the interviews were conducted in a quiet room, participants were time limited and some reported being tired due to the long shift pattern they were working, which could have impacted on their concentration and attention. As a result there were times when participants required additional support and prompts or examples (non-study related example used) to help consolidate the interview process. However, once the initial constructs were elicited and the process undertaken participants understood the procedure and were able to engage more readily. These challenges meant that the interview process was perhaps a little shorter than preferable, lasting approximately an hour; however, all participants elicited a minimum of seven constructs which is considered to be an efficient number (Jankowicz, 2004).

Conclusions

This novel study used repertory grids to explore nursing staff's construal of adults on an inpatient ward. The findings indicate that all staff construed some clients negatively and differentially to other clients. It also highlights the need for support mechanisms that enable staff to formulate clients' difficulties and explore the complexity of interactions

thus gaining more insight and greater compassion. Despite the challenges, the use of repertory grid enabled these differences to be observed.

Clinical implications of the research

The intention of this research was to ensure both guidance for future studies but also that the research had clear clinical implications. The systematic review concluded that there were varied attitudes amongst European nursing staff towards those with mental health difficulties and although various factors that influenced nursing staff attitudes were examined, these findings were inconclusive. However, given questionnaire data did not facilitate the understanding of the mechanisms behind nursing staff's attitudes, further research to elucidate this is necessary. It was possible to provide clinical recommendations in relation to the use of supervision and team reflection/formulation to help improve understanding of behaviours and therefore developing greater compassion towards the individuals nursing staff support. The empirical study confirmed varied findings in relation to nursing staff's attitudes. In particular, those with more cognitive complexity saw clients as more similar to themselves. Moreover, it was identified that clients who were seen as more complex (those with two or more admissions) were viewed less positively than those who had a first time admission to the ward. Clinical implications relating to the use of support mechanisms such as clinical supervision and formulation were reiterated.

Personal reflections

During the recruitment a reflection that persisted throughout was around the working environment and space for staff to 'switch off' during their break time. Although the author had worked within mental health settings, she had not worked within inpatient acute mental health services. Spending time on the ward was enlightening, particularly observing the pressures and limited resources staff had available to them. In particular,

the author reflected on her previous placements where staff members would come together at lunchtime to be able to 'switch off' and socialise, something which was valued. This was in contrast to the small and multi-purpose staff room on the ward. The author reflected on what message this perhaps gave staff in regards to being valued and that a place where 'time out' was important. It was also considered how this might then impact on the issue of compassion, particularly when staff encounter situations that they perceive as difficult and challenging. It made the author curious as to whether not having a place where staff feel able to 'switch off' during breaks or after interactions with those they are supporting that are difficult impacts on them, specifically if not being able to have a relaxing and inviting space for 'time out' during shifts, it is likely lead to increased compassion fatigue and burnout. However, it is noted that not all staff may need a physical space to 'switch off' and some may use other mechanisms such as talking through an incident.

The author was also mindful of the distinctions between the role of researcher and clinician during the recruitment process. When completing the DASS-21 some participants revealed they were experiencing significant stress and/or anxiety difficulties which were related to personal issues outside of work. In such instances it was necessary to ensure that there were no significant risk issues and that the individuals were aware of/had access to support mechanisms; however, the author also had to 'detach' from their clinician identity as further exploration of these issues was not the scope of the research.

The author has enjoyed undertaking this research, they have gained new research assessment and analytical skills as well as becoming more aware of the role of nursing staff within acute settings. It has provided an opportunity to reflect on the differences between professional roles and consider how the role of a clinical psychologist can support not only individual clients but those supporting them as well.

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Appendix A: Clinical Psychology & Psychotherapy

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 - Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
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Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press. and so on.

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Nielsen, M. E. (n.d.). *Notable people in psychology of religion*. Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

6. Journal Article from Database

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7. Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology, 20*, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database. <http://www.psywww.com/psyrelig/psyrelpr.htm>

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Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press. <http://www.psywww.com/psyrelig/psyrelpr.htm>

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Appendix B: Quality assessment tool
Effective Public Health Practice Project (EPHPP) for
quantitative studies & EPHPP dictionary

NB: Deleted sections denote components that were not used as part of the quality assessment tool rating.

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES



COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

- 1 80 - 100% agreement
- 2 60–79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify _____
- 8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No _____ Yes

If Yes, was the method of randomization described? (See dictionary)

No _____ Yes

If Yes, was the method appropriate? (See dictionary)

No _____ Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
-------------------	--------	----------	------

See dictionary	1	2	3
---------------------------	--------------	--------------	--------------

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

- 1 Yes
- 2 No
- 3 Can't tell

The following are examples of confounders:

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

- 1 80 – 100% (most)
- 2 60 – 79% (some)
- 3 Less than 60% (few or none)
- 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

~~D) BLINDING~~

~~**(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?**~~

- ~~1 Yes~~
- ~~2 No~~
- ~~3 Can't tell~~

~~**(Q2) Were the study participants aware of the research question?**~~

- ~~1 Yes~~
- ~~2 No~~
- ~~3 Can't tell~~

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were data collection tools shown to be reliable?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS**(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**

- 1 Yes
- 2 No
- 3 Can't tell
- 4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell
- 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY**(Q1) What percentage of participants received the allocated intervention or exposure of interest?**

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

(Q2) Was the consistency of the intervention measured?

- 1 Yes
- 2 No
- 3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

- 4 Yes
- 5 No
- 6 Can't tell

H) ANALYSES**(Q1) Indicate the unit of allocation (circle one)**

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

- 1 Yes
- 2 No
- 3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

- 1 Yes
- 2 No
- 3 Can't tell

GLOBAL RATING**COMPONENT RATINGS**

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	SELECTION BIAS	STRONG	MODERATE	WEAK
		1	2	3
B	STUDY DESIGN	STRONG	MODERATE	WEAK
		1	2	3
C	CONFOUNDERS	STRONG	MODERATE	WEAK
		1	2	3
D	BLINDING	STRONG	MODERATE	WEAK
		1	2	3
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK
		1	2	3
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK
		1	2	3
				Not

GLOBAL RATING FOR THIS PAPER (circle one):

- | | | |
|---|----------|----------------------------|
| 1 | STRONG | (no WEAK ratings) |
| 2 | MODERATE | (one WEAK rating) |
| 3 | WEAK | (two or more WEAK ratings) |

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

- | | |
|---|---|
| 1 | Oversight |
| 2 | Differences in interpretation of criteria |
| 3 | Differences in interpretation of study |

Final decision of both reviewers (circle one):

- | | |
|---|-----------------|
| 1 | STRONG |
| 2 | MODERATE |
| 3 | WEAK |

Quality Assessment Tool for Quantitative Studies Dictionary



The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.

If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)

An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)

An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study

A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after))

The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series

A time series consists of multiple observations over time. Observations can be on the same units (e.g. individuals over time) or on different but similar units (e.g. student achievement scores for particular grade and school). Interrupted time series analysis requires knowing the specific point in the series when an intervention occurred.

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

~~(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.~~

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs. Score

NO if either the numbers or reasons for withdrawals and drop-outs are not reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

~~The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.~~

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Component Ratings of Study:

For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS

Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). ‘Moderate’ may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can’t tell).

Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

~~B) DESIGN~~

~~**Strong:** will be assigned to those articles that described RCTs and CCTs.~~

~~**Moderate:** will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.~~

~~**Weak:** will be assigned to those that used any other method or did not state the method used.~~

C) CONFOUNDERS

Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1). **Moderate:** will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2). **Weak:** will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

~~D) BLINDING~~

~~**Strong:** The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and** the study participants are not aware of the research question (Q2 is 2).~~

~~**Moderate:** The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2); **or** blinding is not described (Q1 is 3 and Q2 is 3).~~

~~**Weak:** The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1).~~

E) DATA COLLECTION METHODS

Strong: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

Moderate: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

Weak: The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity

are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:

Strong: will be assigned when the follow-up rate is 80% or greater (Q2 is 1).

Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q2 is 5 (N/A).

Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Appendix C: Quality assessment rating table

Quality Assessment Rating Table: The Adapted EPHPP

Authors	A) Selection Bias		B) Study Design	C) Confounders		D) Blinding	E) Data Collection Methods		F) Withdrawals & drop-outs		G) Intervention Integrity	H) Analyses: Q3 statistical methods appropriate for study design	Global Rating
	Q1	Q2		Q1	Q2		Q1	Q2	Q1	Q2			
James & Cowman 2007	1	3	X	3	4	X	3	3	4	3	X	No -Only descriptive	Weak
	Weak			Weak			Weak						
Kukulu & Ergun 2007	1	2	X	3	4	X	3	3	4	2	X	No-only descriptives. Could have looked at factors that might explain attitude e.g. years experience	Weak
	Moderate			Weak			Weak		Moderate				
Munro & Baker 2007	1	3	X	3	4	X	1	1	4	3	X	Yes	Weak
	Weak			Weak			Strong		Weak				
Webb & McMurrin 2007	4	4	X	3	4	X	1	1	4	4	X	Yes	Weak
	Weak			Weak			Strong		Weak				
Bjorkman et al. 2008	1	1	X	1	1	X	3	3	4	1	X	Yes	Moderate
	Strong			Strong			Weak		Strong				
Rao et al 2009	1	3	X	3	4	X	1	1	4	3	X	Yes	Weak
	Weak			Weak			Strong		Weak				
Chambers et al. 2010	1	2	X	1	1	X	1	1	4	2	X	Yes	Strong
	Moderate			Strong			Strong		Moderate				
Bodner et al. 2011	2	5	X	1	1	X	3	3	4	1	X	Yes	Weak
	Weak			Strong			Weak		Moderate				

Authors	A) Selection Bias		B) Study Design	C) Confounders		D) Blinding	E) Data Collection Methods		F) Withdrawals & drop-outs		G) Intervention Integrity	H) Analyses: Q3 statistical methods appropriate for study design	Global Rating
	Q1	Q2		Q1	Q2		Q1	Q2	Q1	Q2			
Hansson et al. 2011	2	3	X	3	4	X	1	1	4	3	X	No- used t-test assumed data normally distributed. Could have looked at and controlled for demographic differences between staff and patients	Weak
	Weak			Weak			Strong		Weak				
Linden & Kavanagh 2012	1	2	X	1	4	X	1	1	4	2	X	Yes but could have used MANCOVA to control for covariates e.g. gender	Moderate
	Moderate			Weak			Strong		Moderate				
Tyson 2013	3	3	X	3	4	X	3	1	4	3	X	Yes	Weak
	Weak			Weak			Moderate		Weak				
Martensson et al. 2014	2	2	X	1	1	X	1	1	4	2	X	Yes	Strong
	Moderate			Strong			Strong		Moderate				
Bodner et al. 2015	1	3	X	1	1	X	3	1	4	3	X	Yes	Weak
	Weak			Strong			Moderate		Weak				
Natan et al. 2015	2	1	X	1	4	X	1	1	4	1	X	Yes	Moderate
	Moderate			Weak			Strong		Strong				

Appendix D: University Research Ethics Committee approval letter
and Research & Development approval letter

Ref: *ethics/15157*

Dr Anja Wittkowski
School of Psychological Science
Zochonis Building S25

6th May 2015

Dear Dr Wittkowski

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Study title: A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Research Ethics Committee 6

I write to thank you and Dr Addison for coming to meet the Committee on 15th April 2015. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

This approval is effective for a period of five years. If the project continues beyond that period an application for amendment must be submitted for review. Likewise, any proposed changes to the way the research is conducted must be approved via the amendment process (see below). Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. [Amendments](#)
2. [Breaches and adverse events](#)
3. [Notification of Progress/End of the Study](#)

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a feedback sheet [<https://survey.manchester.ac.uk/pssweb/index.php/535286/lang-en>]

We hope the research goes well.

Yours sincerely



Ms. Genevieve Pridham
Secretary to University Research Ethics Committee 2 and 6

RE: APPROVED: Ethics Amendment request: Addison: A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward (Ref: 15157)

Victoria Nola Addison

Sent: 08 January 2016 11:40

To: Genevieve Pridham

Cc: Anja Wittkowski

Hi Genevieve,

Thank you for your quick response and approving the amendment.

Best wishes

Vicky

Vicky Addison
Trainee Clinical Psychologist
University of Manchester
Division of Clinical Psychology
2nd Floor Zochonis Building
Brunswick Street,
Manchester M13 9PL

Victorianola.addison@postgrad.manchester.ac.uk

From: Genevieve Pridham

Sent: 08 January 2016 09:32

To: Victoria Nola Addison; Research Ethics

Cc: Anja Wittkowski

Subject: APPROVED: Ethics Amendment request: Addison: A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward (Ref: 15157)

Dear Vicky,

Many thanks for submitting through your amendment request for project 15157 which has now been approved. Your documentation has been suitably updated to reflect the proposed changes, please ensure you use this documentation.

Good luck with the project.

Best wishes,

Genevieve

Ms. Genevieve Pridham

Secretary to University of Manchester Ethics Committees 2 and 6 | Research Governance, Ethics and Integrity Assistant | Directorate of Research and Business Engagement Support Services | Christie Building | University of Manchester | Oxford Road | Manchester M13 9PL

Phone: 0161-275-2674 | **Website:** [Research Governance, Ethics and Integrity](#) | **Twitter:** [@RGEIUoM](#)

From: Victoria Nola Addison

Sent: 06 January 2016 16:53

To: Research Ethics

Cc: tim.stibbs@manchester.ac.uk; Genevieve Pridham; Anja Wittkowski

Subject: Ethics Amendment request: Addison: A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward (Ref: 15157)

Dear Chair of Research Ethics Committee 6,

RE: Ethics Amendment request: ***A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward (Ref: 15157)***

We would like to request a minor amendment to the REC application submitted for the above study. Please find attached the completed UREC amendment form and the amended PIS sheet.

Best wishes

Vicky

Vicky Addison
Trainee Clinical Psychologist
University of Manchester
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Manchester M13 9PL

Victorianola.addison@postgrad.manchester.ac.uk



**Submission Point for
Electronic Approval of
Research**

Research & Innovation Office
 Manchester Mental Health & Social Care Trust
 3rd Floor
 Rawnsley Building
 Manchester Royal Infirmary
 Hathersage Road
 Manchester
 M13 9WL
t 0161 276 3311

11 May 2015

Dr Victoria Addison
 School of Psychological Sciences
 Clinical Psychology
 2nd Floor Zochonis Building
 University of Manchester
 Brunswick Street
 M13 9PL

Dear Victoria

Re: Research Governance Decision Letter

Information for ID Badge if required:

Research Project Ref No: 1386
 Expiry Date: 30 September 2016

You must take this letter with you.

SPEAR/Trust Project Reference: 1386

Project Title : A repertory grid study of staff construing adult service users

HRA No: n/a (staff only study)

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study and all HRA amendments up to the date of this letter. Please note when contacting the R&I office about your study you must always provide the project reference numbers provided above.

Trust R&I approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research. This letter also gives NHS permission, on behalf of Rotherham Doncaster and South Humber NHS Foundation Trust, to undertake the protocol specified research activities within the Early Intervention Service.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&I Office should you require any further information. You may need this letter as proof of your approval.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. These are demonstrated in the enclosed proforma invoice. We can confirm that in this instance we will not charge for these. However we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

You will need to contact us before any new researchers join your team as they will need Trust permission before they start work on the project.

A condition of approval is that you comply with the Trusts Argyll (Lone Working Policy) System (Contact Phil Moffatt on 0161 277 1231) where appropriate.

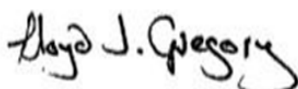
It is your responsibility to contact us a week prior to the expiry date we have recorded for this project to let us know if you wish to extend it, as we will need to send a new approval letter. You will also need to let us know immediately if for any reason the project finishes earlier.

It is a condition of our Trust approval that on completion of this study we are in receipt of an end of study report summary and a copy of the Ethics letter confirming that they have closed the study, we will remind you of this nearer the time. You will also be asked to complete an audit form for each year your study is supported by this Trust (including the year of its completion) this approval requirement and failure or refusal to complete it may result in Trust approval being withdrawn.

By beginning your research you are agreeing to all the terms and conditions as stated within this letter.

May I wish you every success with your research and if you have any queries do not hesitate to contact the R&I Team.

Yours sincerely



Dr Lloyd Gregory
Research & Innovation Manager

cc : Dr Brigid Corrigan – Local Collaborator
Ms Lynne Macrae - Research Governance Sponsor, University of Manchester

Enc: Approval Conditions Leaflet
Induction & ID Badge Information
TrustTECH Leaflet
Lone Working Policy
Dummy invoice

Appendix E: Participant information sheet
& Consent form


 MANCHESTER
1824

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward


 MANCHESTER
1824

School of Psychological
Sciences
Clinical Psychology 2nd Floor
Zochonis Building
Brunswick Street
Manchester
M13 9PL
victorianola.addison@
postgrad.manchester.ac.uk

Participant Information Sheet

Title:- A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Invitation

We would like to invite you to take part in a research study about how staff construe (i.e. view) adults who have been admitted to a psychiatric inpatient ward (Bronte Ward) and about the relationship between compassionate care and staff views. Before you decide whether or not to participate it is important for you to understand why the research is being done and what it would involve for you if you were to take part.

Please take time to read the following information carefully, talk to others about the study if you wish and ask if anything is not clear or if you would like more information. Please take your time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of the study is to find out more about the relationship between compassionate care and how staff construe (i.e. how we view/form ideas about) adults of working age who are experiencing mental health difficulties who have been admitted either as voluntary informal patients or who have been detained under the Mental Health Act to an inpatient ward (Bronte Ward). The study aims to understand how you construe (view) yourself, clients and others you care about/care for.

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Why have I been invited to take part in this study?

This research study is specifically interested in staff nurses and nursing assistants/support workers who work with adults who are experiencing mental health difficulties who have been admitted either as voluntary informal patients or who have been detained under the Mental Health Act to an inpatient ward (Bronte Ward). You have been invited to take part in the study because you are currently working on Bronte Ward (inpatient ward) and have therefore been identified as a suitable participant in this research study. In total, we will need 14 other people to take part on this study.

Do I have to take part?

No. It is entirely your choice whether or not you want to take part. Reading this participant information sheet does not commit you to participating within the study. Taking part in this study is voluntary, which means that it is completely up to you whether you decide to join the study or not. Even if you do decide to take part, you can withdraw at any time during the interview without giving a reason. The only time you would not be able to withdraw your data from the study is once all participant data has been analysed.

Your decision to participate or not in this study will **not** affect your employment. If you decide to participate I will ask you to sign a consent form to say that you want to take part and are willing to take part; however this does not commit you to participate in the study.

What will happen if I take part?

If you take part any questions that you have about the study will be answered and if you are still happy to participate you will then be asked to sign a consent form. A convenient time to meet during your shift on Bronte Ward, will then be arranged. The initial interview will take approximately 40-60 minutes. During this time you will be asked to complete a short demographic questionnaire and a brief questionnaire about your current mood (Depression, Anxiety and Stress Scale: DASS-21).

You will then be asked to complete a Repertory Grid interview which will be audio recorded. During the interview:

- a. You will be presented with three elements (e.g. an individual client who you find it easier to care for; your hypothetical ideal client & a person you

- A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward (care about/care for), and asked to identify how two of the elements are similar and why they are different to the third.
- b. This will be continued until you can no longer think of anymore different constructs (i.e. views/ideas) about the elements.
 - c. You will then be asked to rate the remaining 8 elements between the two constructs.

Once the grids have been analysed, a follow up session will be arranged and you will be invited to review your grid for accuracy. This will take approximately 20-30 minutes.

To thank you for your time and participating in the study you will receive £10 cash.

What are the possible disadvantages and risks of taking part?

There are no predicted disadvantages or risks to taking part, you will be required to spend up to 90 minutes of your time completing an interview, two brief questionnaires and reviewing your repertory grid for accuracy. It is possible that you may become disinterested whilst participating and you may wish to withdraw from the study. If this occurs you can stop the repertory grid interview at any time.

What are the possible benefits of taking part?

We hope that you will find participating interesting. Taking part may provide you with the opportunity to reflect upon your professional role and your relationship with clients and people you know personally, it may help you to better understand the way you view/look at the world. It is hoped that the findings of this study will be used to further knowledge and understanding of working with this particular client group and that the study findings will highlight areas where further support mechanisms for staff are needed. This may then contribute to continued improved care for service users.

Will taking part be kept confidential?

All information collected will be kept confidential and in line with the Data Protection Act. Names and identifiable information will be removed so you cannot be recognised; in replacement you will be given a code/participant number to represent your name, so that you are not identifiable. I will have the details of all participants' names and codes/numbers but these will not be kept in the same place to ensure your confidentiality. Consent forms will contain your name however **no** codes/participant

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

numbers will be identified on the consent form thus it will not be possible to link you to a specific participant code/number. The only people who will have direct access to the data you provide will be the researcher, Vicky Addison and Academic Supervisors Dr Anja Wittkowski and Dr Dougal Hare. Upon completion of the study Anja Wittkowski will have an electronic copy of the research data for a maximum of 5 years. If the research is published in an academic journal any publications will not identify the location where staff were recruited from, this will ensure participant confidentiality.

All consent forms and questionnaire data will be stored separately in a locked private cupboard at the University of Manchester. All interviews will be recorded on an encrypted Dictaphone and will be destroyed following completion of the research. All information which is collected about you will be kept under strict confidentiality, unless a disclosure is made which indicates that you or somebody else may be at risk of harm.

Study data and material may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS trust, for monitoring and auditing purposes, and this may well include access to personal information.

What if there are any problems?

As mentioned before, you can withdraw from the study at any time. It is unlikely that anything would go wrong whilst participating. But, if there is a problem, you may contact me in the first instance or you can contact my supervisors (Dr Anja Wittkowski and Dr Dougal Hare). Any complaint you have about the study will be resolved promptly; and information will be provided by phone or in writing to inform you of how the complaint has been addressed.

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Researcher:
Vicky Addison
School of Psychological Sciences
2nd Floor Zochonis Building
Brunswick Street
Manchester
M13 9PL

Tel: 0161 306 0400

Victorianola.addison@postgrad.manchester.ac.uk

Academic Supervisors:
Dr Anja Wittkowski or
Dr Dougal Hare
School of Psychological Sciences
2nd Floor Zochonis Building
Brunswick Street
Manchester
M13 9PL

Tel: 0161 306 0400

Anja.wittkowski@manchester.ac.uk

Dougal.hare@manchester.ac.uk

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Governance and Integrity Team by either writing to 'The Research Governance and Integrity Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research.complaints@manchester.ac.uk, or by telephoning 0161 275 8093 or 275 2674

What will happen if I don't want to carry on with the study?

You can choose to withdraw at any stage. With your permission, we may continue to use any information that has been obtained with your consent.

What will happen to the results of the research?

The study will form part of my thesis for the Doctorate in Clinical Psychology which will be submitted to the University of Manchester. It is hoped that the study will also be published in an academic journal and it may also be presented at conferences.

Who is organising and funding the research?

The research is funded by the School of Psychological Sciences, University of Manchester.

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee (REC), to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the University of Manchester Research Ethics Committee (UREC).

Further information and contact details

If you require any further information or have any questions, please do not hesitate to contact me at:

Vicky Addison
School of Psychological Sciences 2nd Floor
Zochonis Building Brunswick Street
Manchester M13 9PL

Tel: 0161 306 0400

Victorianola.addison@postgrad.manchester.ac.uk



MANCHESTER
1824

School of Psychological
Sciences
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M13 9PL

victorianola.addison@
postgrad.manchester.ac.uk

CONSENT FORM

Title of Project: **A repertory grid study of staff
construing adult service users admitted to a
psychiatric inpatient ward**

Name of Researcher: Vicky Addison

**Please
initial
box**

1. I confirm I have been provided with the information sheet dated 06/01/2016 (Version 3) the above study and that I have had the opportunity to read the information sheet and had it fully explained to me.
2. I confirm that I am fully aware of what is required from me and understand all procedures as outlined in the information sheet dated 06/01/2016 (Version 3). I have had the time and opportunity to consider the information, ask any questions and had these answered satisfactorily.
3. I am fully aware that my participation is voluntary and that I may withdraw from the study at any time without detriment and without giving any reason, and that my employment will not be affected.
4. I agree to take part in the above study.
5. I agree to my interview being recorded on a digital recorder.
6. I wish to participate in the follow-up session to receive feedback on the outcome of my repertory grid interview data.
7. I agree that direct quotes from the interview may be used in the write up of the of the study and that any direct quotes used will be anonymised.
8. I agree that information and resultant data collected can be published and that personal details will be made anonymous within the paper if published.



A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

9. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data.

Name: _____ Signature: _____ Date: _____

Researcher: _____ Signature: _____ Date: _____

When complete, 1 copy for participant; 1 (original) for researcher site file.

Appendix F: Repertory grid recruitment poster

Do you work closely with service users? Are you interested in research?

Researchers at the University of Manchester need **your** help.

We want to know more about how staff view themselves, service users they care for and others (e.g. family, friends) they care for/care about.



What will I have to do?

The researcher will meet with you on the inpatient ward at a time that is convenient for you, once you have agreed to take part.

You will be asked to complete a brief questionnaire and participate in a Repertory Grid interview. This will last approximately 40-60 minutes.

During the interview you will be asked to say why three elements (e.g. an individual client who you find it easier to care for; yourself & a person you care about/care for) are similar or different.

To thank you for your time in participating you will receive a Manchester Arndale Gift Voucher.

Please contact the researcher for further information:

Vicky Addison

Telephone: **0161 306 0400**

email: victorianola.addison@postgrad.manchester.ac.uk

or alternatively you can inform the Ward Manager or Ward Matron that you are interested in participating.

Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk	Vicky Addison Telephone: 0161 306 0400 email: victorianola.addison@postgrad.manchester.ac.uk
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Appendix G: Repertory grid interview protocol

Repertory grid interview protocol

The following procedure will be utilised when interviewing each participant. The researcher will already be known to participants as an initial introduction will have taken place during the recruitment process. Participants will have been provided with a Participant Information Sheet outlining the study, informed consent will have also been gained from each person wishing to take part in the study and any questions will have been answered.

1. Introduction

“Hello. I would like to thank you for meeting with me today. The purpose of this study and interview is that I am interested in your views and experiences of the adults that you work with who have either been detained under the mental health act or who are voluntary admissions to the ward. I would like to know more about how they may be similar or different to others you care for or care about outside of the ward. We’ll be using a method called the repertory grid technique to help gather your views and over the next hour I’m going to ask you about clients that you have worked with on the ward. To help me remember what we discuss today I would like to tape record this session. You can ask for me to stop recording at any time. The recording will be transcribed verbatim (word for word) but all indefinable information will be removed and replaced with pseudonyms (false names/information) and the audio recording will then be destroyed.

Anything that you say will be anonymised so that that you will be not be able to be identified, and no one but me will know what you have said. The only exception to this would be if you disclosed any information which suggested yourself or someone else was at risk of harm.

Do you have any questions?”

“By the end of the session we will have collected quite a bit of information about how you view different people. I will then go away and analyse the information you have provided. I would then like to meet with you a second time to go over the results with you and to discuss with you whether the results are an accurate reflection of your views. This will give you a chance to tell me if you feel the results are a true reflection of your views or if there is anything about what the results are showing that you don’t agree with.”

Before we go any further, I need to ask you to sign the consent form and ask you some basic information about yourself and about how you are feeling at present?

Complete demographic information sheet and DASS-21 with participants.

2. Explanation of study procedure and practice example

“I am going to be asking you about clients that you have worked with on the ward and people that you know personally. I will give you eleven short descriptions and ask you to think of people that match these descriptions.”

“I’m going to ask you to think about how these people might be similar to each other and how they might be different from each other. I will ask you to compare these people in groups of three, and ask you to think about an important way that makes two of the people similar to each other, and therefore different from the third person. I will then ask you for the opposite of this.

For example, if your clients on the ward were Simon Cowell, Sharron Osborne and Kate Middleton and you might think that two of these people are similar as they are outgoing people. If you decided that two of the people were outgoing, you may think that the opposite of outgoing is reserved.”

Answer any questions that the participant may have at this point to do with the procedure as described so far.

“Once you have compared the initial three people, I will then ask you to rate the remaining people on the qualities you have mentioned. There are no right or wrong answers; it’s about your own experiences and how you describe things in your own terms.

All information that you provide during this session will be anonymised so that neither you nor the people you think of will be able to be recognised from it.”

“Do you have any questions so far?”

Interviewer to start tape recorder

3. Procedure for choosing elements

Place the role titles in front of the participant.

“I’m going to present you with eleven short descriptions, which should enable you to think of people that you have worked with on the ward or people that you know personally. I’m going to ask you to match these descriptions to people that you know.”

Present the first role title

“On this first card it says “An individual client who you find it easier to care for”.

The researcher hands the participant a 3” x 5” card bearing the role title.

“I would like you to think of a client who you know well who fits that description. In order to remember them during the interview could you either write down either their initials, or another way in which you can remember them on this card.”

“You may find as you go through this list that you will think of someone whose name you have already listed. When this happens, please can you think of a different person who also fits the description, so that you won’t have anybody that appears twice.”

The remainder of the role titles to be presented in a similar way. Following are the remainder role titles used within the procedure.

- An individual client who has a first time admission to Bronte Ward
- An individual client who has a second or more admission to Bronte Ward
- An individual client with a dual diagnosis (client with substance misuse)
- Your hypothetical ideal client
- An individual client who has been compulsorily detained
- A client with whom you had a difficult professional relationship
- A family friend or relative with mental health difficulties
- A person you care about/care for
- Self,
- Ideal self

“I would like you just to think about the people you have matched to the descriptions. Do you think these people are typical and representative of the description that you have matched them with?”

For example, the person that you have chosen who fits the description ‘an individual client who you find it easier to care for’, do you think that that this person is typical/similar to other clients that you have worked with on the ward who you have found it easier to care for? What makes them typical of clients that you work with, who are easier to care for?”

- Identify examples of how person is typical of this description.
- Elicit behavioural examples that the participant thinks makes the person they have chosen typical of that role title.
- If participant indicates that they are not typical, ask participant to choose another person who is more typical of the role title.

If the participant is unable to think of a person that they know to match to a specific role title, this role title should be dropped.

The element “self” and ‘ideal self’ should also be provided to the participant on individual 3” x 5” cards.

Answer any questions that the participant may have at this point.

4. Procedure for eliciting constructs

Present the first triad to the participant.

“I would now like you to tell me in what way are two of these people are alike, but different from the third. Feel free to move the cards if you want to.”

‘Can you give me an example of what you mean by.....?’

‘What would the opposite of.....be?’

Ask the participant to rate the elicited constructs on a scale of 1-5 with 1 being the combined construct e.g. reserved (emergent pole Place on left of grid) and 5 the opposite construct/ single construct e.g. outgoing (Place on right of grid – implicit pole)

The researcher should record the participant's responses on the grid sheet.

5. Procedure for rating the elements

“I am now going to ask you to rate each of the remaining people you have thought about on the [state the elicited construct]. I will ask you to rate the people on a scale of 1 to 5.”

Present rating scale card (1-5) to the participant. Interviewer to write each pole of the elicited construct on a piece of card and to place them at the appropriate ends of the rating scale so that they can be viewed by the participant during the rating procedure.

When participant is asked to rate elements for the first time provide an example which incorporates the construct initially elicited.

Example:

“If you see yourself as quiet you might give yourself a rating of 1, if you see yourself as quiet but not absolutely so, then perhaps you perhaps you might rate yourself as a 2. On the other hand if you see yourself as loud, you may wish to give yourself a 5 or a 4 which is slightly less extreme”.

Participant to rate each of the remaining elements in turn on the construct elicited.

It is possible that when participant is asked to rate the element 'self' or 'ideal self' for the first time, participant may feel uncomfortable- explain to the participant that it is common for people to feel uncomfortable when rating themselves in front of a person they don't know well. Clarify that all data will be kept confidential and that they will be unable to be recognised individually from the research.

Place each element card (showing the code reminders) to the participant to aid recall. Provide participant with the opportunity to state whether the construct does not apply to any of the elements. Researcher to record participant's responses on a grid sheet. Chart and ratings to be kept out of participants view whilst ratings are being made.

Repeat steps 4 and 5 until the participant has elicited 10 constructs or until the participant is unable to elicit any more constructs.

6. Debrief

‘Thank you very much for completing the interview. How did you feel about the process?’

‘So the next step now that we have this information is that I’m going to go away and analyse the information you have given me using a statistical analysis computer program. This will provide a map like this one here (show example of completed bi-plot to participant).

I would then like to meet with you again to discuss the results and to identify if you feel they are an accurate reflection of your views. Would it be possible to meet again so we can go through the results?’

‘Do you have any questions?’

‘Thank you very much for taking the time to meet with me.’

Provide participant with voucher for time and participation. Ask participant to sign to say they have received voucher.

****Interviewer to stop the tape recorder.****

Feedback session

‘Thank you for meeting with me again.

This session is to discuss the analysis of the information you gave me and to see whether this fits with your views and what you felt you talked about the last time we met.

As you may remember, I asked you to think about clients that you had worked with on the ward and about people that you know personally. I asked you to think about important ways that clients, people you care for/care about and yourself were similar or different to each other.

Through this process you developed a number of constructs and I asked you to rate the people that you had chosen to include in the interview, on these constructs.

Provide participants with the element rating cards that they used within the interview

Present participants with visual representation (PinGrid) of their repertory grid.

“Overall do you think this fits with how you perceive the different individuals that you included within the interview?”

“Are there any things which I have just described which you don’t agree with, or which you feel doesn’t fit with your own views?”

“Do you have any questions about what I have just described?”

“Overall, how did you find the process of completing the repertory grid interview?”

“I would like to thank you for taking the time to participate in the research”.

Appendix H: Depression, Anxiety
& Stress Scale (DASS-21)



BLACK DOG INSTITUTE

DASS 21 NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 1 Did not apply to me at all - NEVER
- 2 Applied to me to some degree, or some of the time - SOMETIMES
- 3 Applied to me to a considerable degree, or a good part of time - OFTEN
- 3 Applied to me very much, or most of the time - ALMOST ALWAYS

					FOR OFFICE USE						
					N	S	O	AA	D	A	S
1	I found it hard to wind down	0	1	2	3						
2	I was aware of dryness of my mouth	0	1	2	3						
3	I couldn't seem to experience any positive feeling at all	0	1	2	3						
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3						
5	I found it difficult to work up the initiative to do things	0	1	2	3						
6	I tended to over-react to situations	0	1	2	3						
7	I experienced trembling (eg, in the hands)	0	1	2	3						
8	I felt that I was using a lot of nervous energy	0	1	2	3						
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3						
10	I felt that I had nothing to look forward to	0	1	2	3						
11	I found myself getting agitated	0	1	2	3						
12	I found it difficult to relax	0	1	2	3						
13	I felt down-hearted and blue	0	1	2	3						
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3						
15	I felt I was close to panic	0	1	2	3						
16	I was unable to become enthusiastic about anything	0	1	2	3						
17	I felt I wasn't worth much as a person	0	1	2	3						
18	I felt that I was rather touchy	0	1	2	3						
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3						
20	I felt scared without any good reason	0	1	2	3						
21	I felt that life was meaningless	0	1	2	3						
TOTALS											

Scoring the DASS

The scale to which each item belongs is indicated by the letters D (Depression), A (Anxiety) and S (Stress). For each scale (D, A & S) sum the scores for identified items. Because the DASS 21 is a short form version of the DASS (the Long Form has 42 items), the final score of each item groups (Depression, Anxiety and Stress) needs to be multiplied by two (x2).

Interpreting the DASS

Once multiplied by 2, each score can now be transferred to the DASS profile sheet, enabling comparisons to be made between the three scales and also giving percentile rankings and severity labels.

DASS Severity Ratings

(Don't forget to multiply summed scores by x2)

Severity	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Appendix I: Interview material.

Demographic information sheet

Flash cards

Repertory grid recording sheet

Construct description sheet

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Demographic information sheet

Participant number:

Date information taken: ____/____/20____

Demographic data

AGE- years months

GENDER- Male Female

ETHNICITY-

EMPLOYMENT TYPE- Staff nurse (qualified) Nursing assistant/HCA (non-qualified)

Part-time or Full-time

How many years have you worked as Staff nurse/Nursing assistant on X Ward? (Years, months).

Element Cards:

An individual client who has a first time admission to Bronte Ward.	An individual client who has a second or more admission to Bronte Ward.
An individual client who you (i.e. staff member) find it easier to care for.	Your hypothetical ideal client.
A client with whom you had a difficult professional relationship.	A family friend or relative with mental health difficulties.
Self.	Ideal self.
An individual client with a dual diagnosis (client with substance misuse).	A person you care about/care for.
An individual client who has been compulsorily detained.	

A repertory grid study of staff construing adult service users admitted to a psychiatric inpatient ward

Repertory Grid Schedule

Left (Emergent Pole) Paired construct	Client - first time admission	Client- 2+ admission	Client- dual diagnosis	Client find easier	Hypothetical ideal client	Person- compulsory det	Client- difficult relationship	Family/friend with MH diff	Someone you care for/about	Self	Ideal Self	Right (Implicit Pole) Single Construct
1												5

Construct description sheet:			
Paired (Emergent) construct		Single (Implicit) construct	

Appendix J: Individual repertory grid data

A range of data, as well as the pingrid, is presented for each participant.

Eigenvalues were calculated using Principal Components Analysis. The eigenvalue for component 1 is an indicator of the tightness of the construing, with higher values indicating tighter construing.

Standardised Euclidean distances were calculated using Slater analysis. Distances less than 0.50 indicate highly similar elements, those over 1.50 imply highly dissimilar elements. These are indicated on the tables, with scores below 0.50 highlighted in green and over 1.50 highlighted in red.

The elements are as follows:

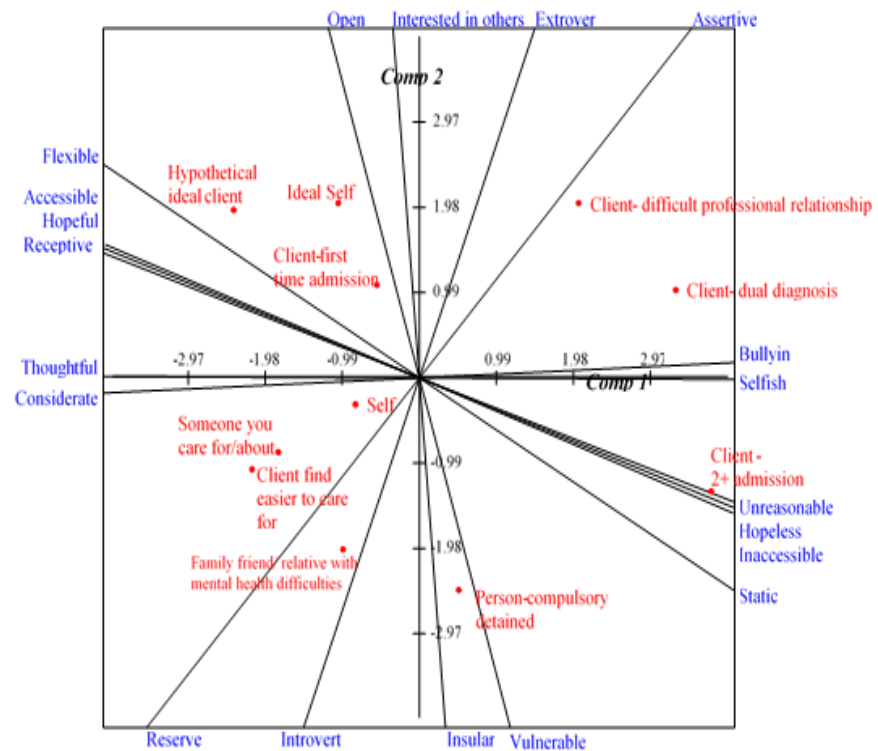
- 1) An individual client who has a first time admission to XX Ward,
- 2) An individual client who has a second or more admission to XX Ward,
- 3) An individual client with a dual diagnosis (client with substance misuse),
- 4) An individual client who you (i.e., staff member) find easier to care for,
- 5) Your hypothetical ideal client.
- 6) An individual client who has been compulsorily detained,
- 7) A client with whom you had a difficult professional relationship
- 8) A family friend or relative with mental health difficulties,
- 9) A person you care about/care for,
- 10) Yourself (now)
- 11) Your ideal self.

Participant 1:

Eigenvalues:

- Component 1 accounts for 48.65% of the variance
- Component 2 accounts for 29.54% of the variance
- Component 3 account for 10.66% of the variance

Pingrid:



Distance between elements (standardised element Euclidean distances)

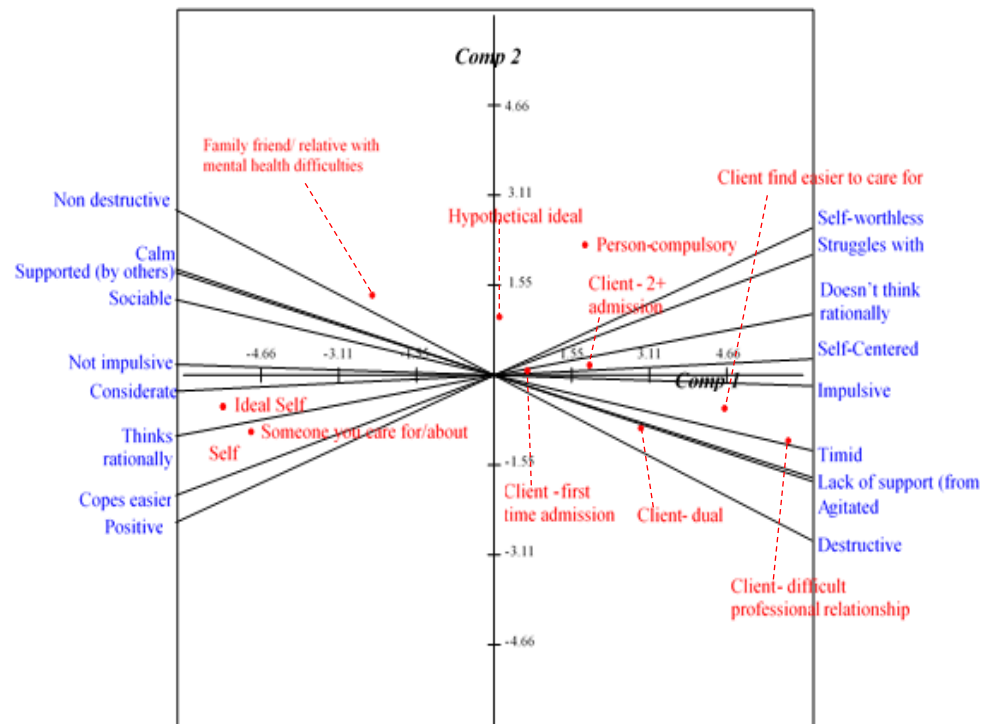
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	1.22	0									
3	1.08	1.08	0								
4	0.73	1.49	1.42	0							
5	0.51	1.64	1.47	0.83	0						
6	0.89	1.00	1.19	0.83	1.26	0					
7	0.73	1.03	0.65	1.26	1.05	1.15	0				
8	0.86	1.30	1.26	0.56	1.05	0.69	1.22	0			
9	0.69	1.40	1.36	0.51	0.73	0.80	1.15	0.51	0		
10	0.51	1.19	1.15	0.51	0.73	0.73	0.89	0.61	0.46	0	
11	0.40	1.40	1.19	0.83	0.46	1.17	0.83	1.05	0.80	0.65	0

Participant 2:

Eigenvalues:

- Component 1 accounts for 82.42% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

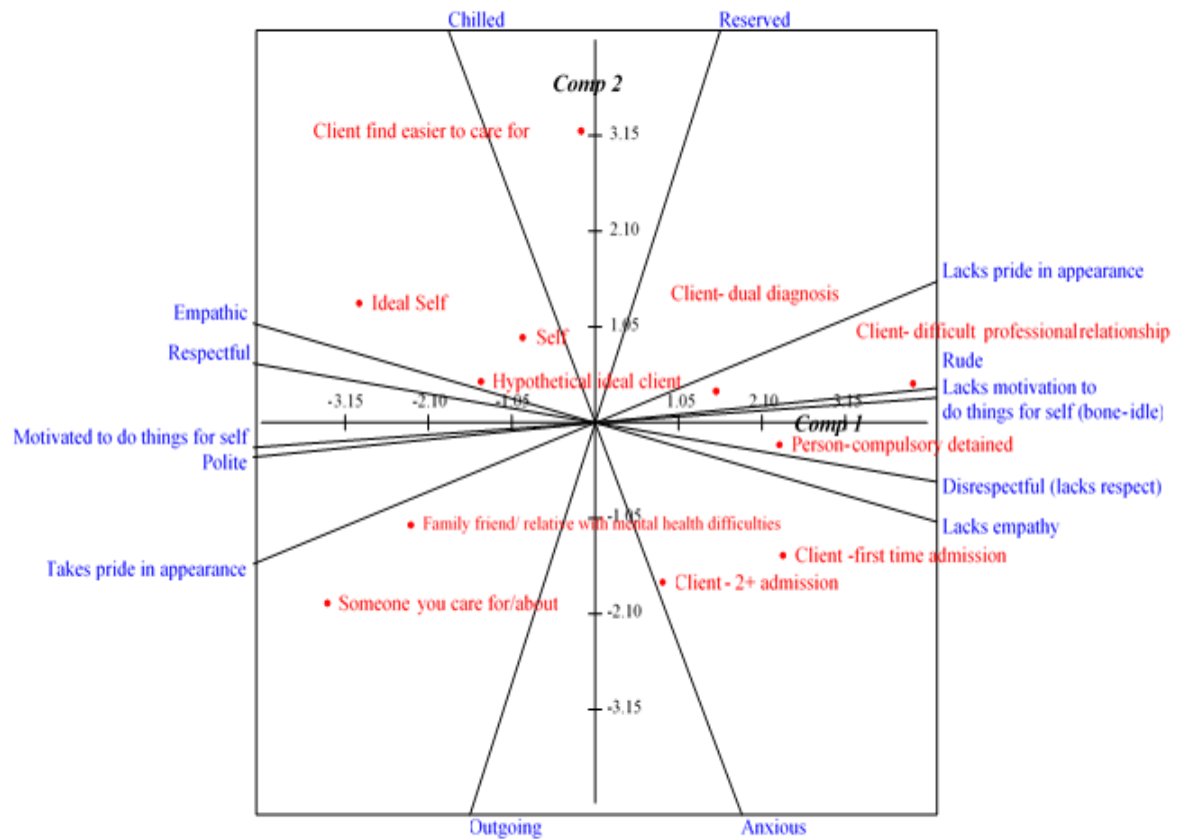
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.39	0									
3	0.62	0.58	0								
4	0.75	0.68	0.42	0							
5	0.39	0.56	0.62	0.88	0						
6	0.48	0.58	0.64	0.70	0.42	0					
7	0.91	0.75	0.62	0.51	1.01	0.89	0				
8	0.73	0.83	0.99	1.23	0.62	0.85	1.46	0			
9	1.01	1.24	1.37	1.63	0.93	1.25	1.83	0.70	0		
10	0.93	1.16	1.29	1.54	0.91	1.21	1.74	0.62	0.23	0	
11	1.01	1.24	1.37	1.63	0.93	1.25	1.83	0.70	0.00	0.23	0

Participant 3:

Eigenvalues:

- Component 1 accounts for 53.47% of the variance
- Component 2 accounts for 21.87% of the variance
- Component 3 accounts for 10.52% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

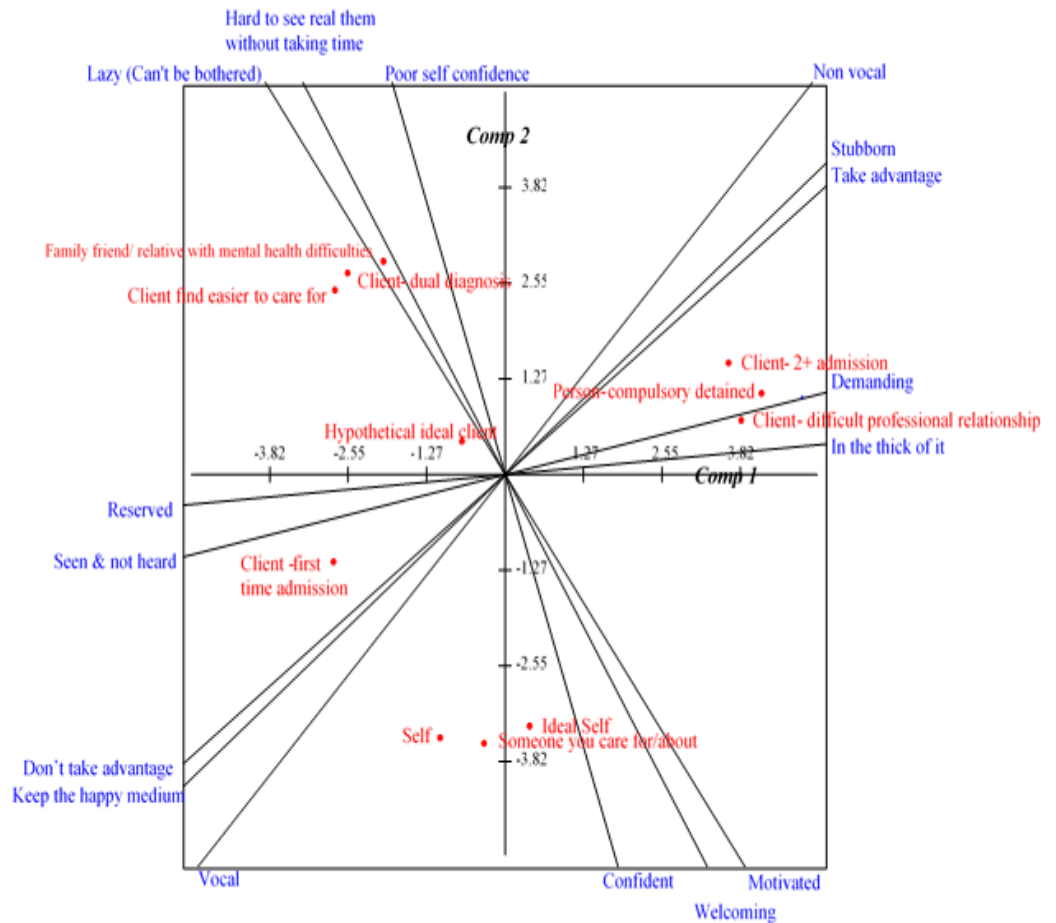
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.74	0									
3	0.68	0.74	0								
4	1.23	1.15	0.88	0							
5	1.05	0.74	0.86	0.71	0						
6	0.57	0.57	0.64	0.96	0.83	0					
7	0.98	0.88	0.98	1.17	1.23	0.61	0				
8	1.17	0.74	1.09	1.07	0.52	1.07	1.43	0			
9	1.34	0.98	1.27	1.32	0.71	1.32	1.71	0.48	0		
10	1.05	0.92	0.86	0.83	0.68	1.03	1.27	.80	1.03	0	
11	1.39	1.09	1.12	0.83	0.43	1.19	1.59	.68	0.83	0.80	0

Participant 4:

Eigenvalues:

- Component 1 accounts for 43.75% of the variance
- Component 2 accounts for 37.75% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

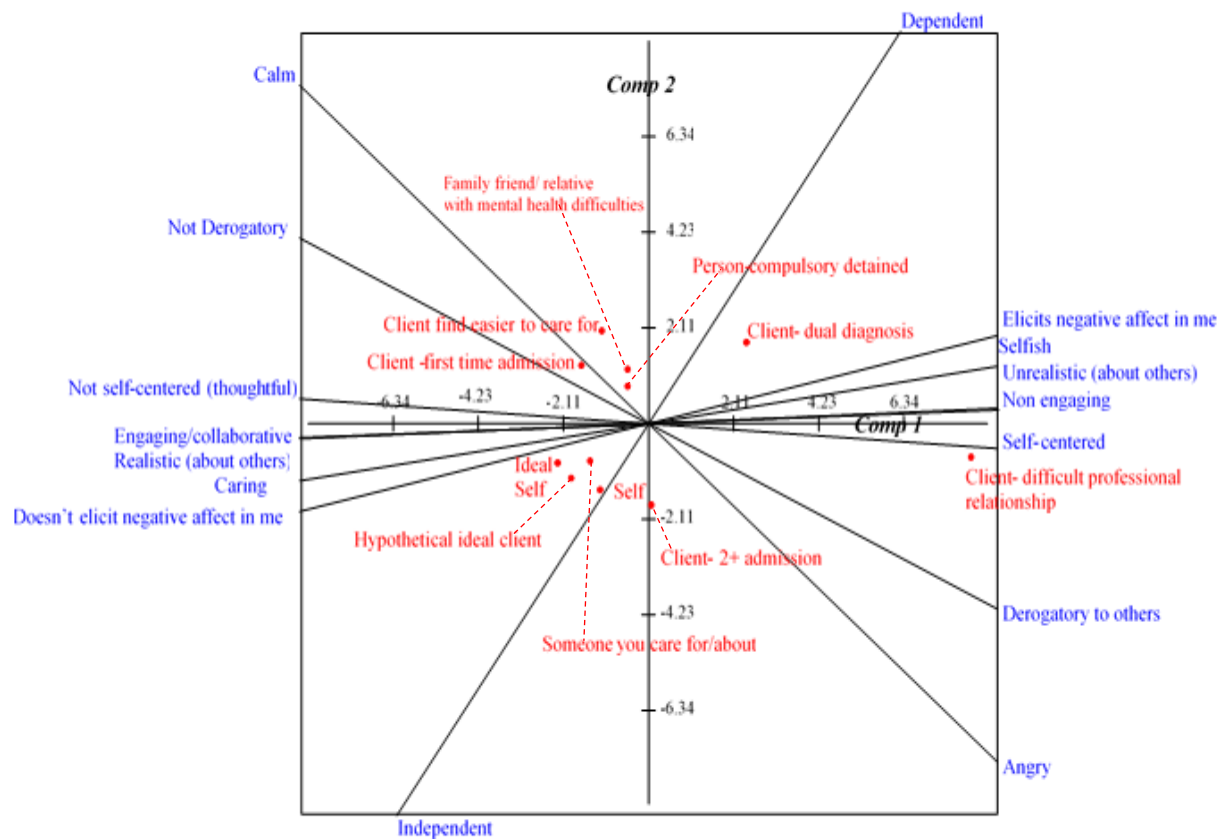
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	1.27	0									
3	0.71	1.16	0								
4	0.69	1.23	0.17	0							
5	0.69	0.95	0.67	0.74	0						
6	1.33	0.62	1.25	1.31	0.93	0					
7	1.31	0.79	1.27	1.24	1.11	0.77	0				
8	0.77	1.10	0.30	0.35	0.60	1.19	1.19	0			
9	0.69	1.20	1.16	1.15	0.77	1.19	1.16	1.18	0		
10	0.55	1.25	1.11	1.10	0.81	1.26	1.24	1.15	0.25	0	
11	0.76	1.11	1.20	1.19	0.87	1.12	1.07	1.16	0.39	0.46	0

Participant 5:

Eigenvalues:

- Component 1 accounts for 69.59% of the variance
- Component 2 accounts for 15.81% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

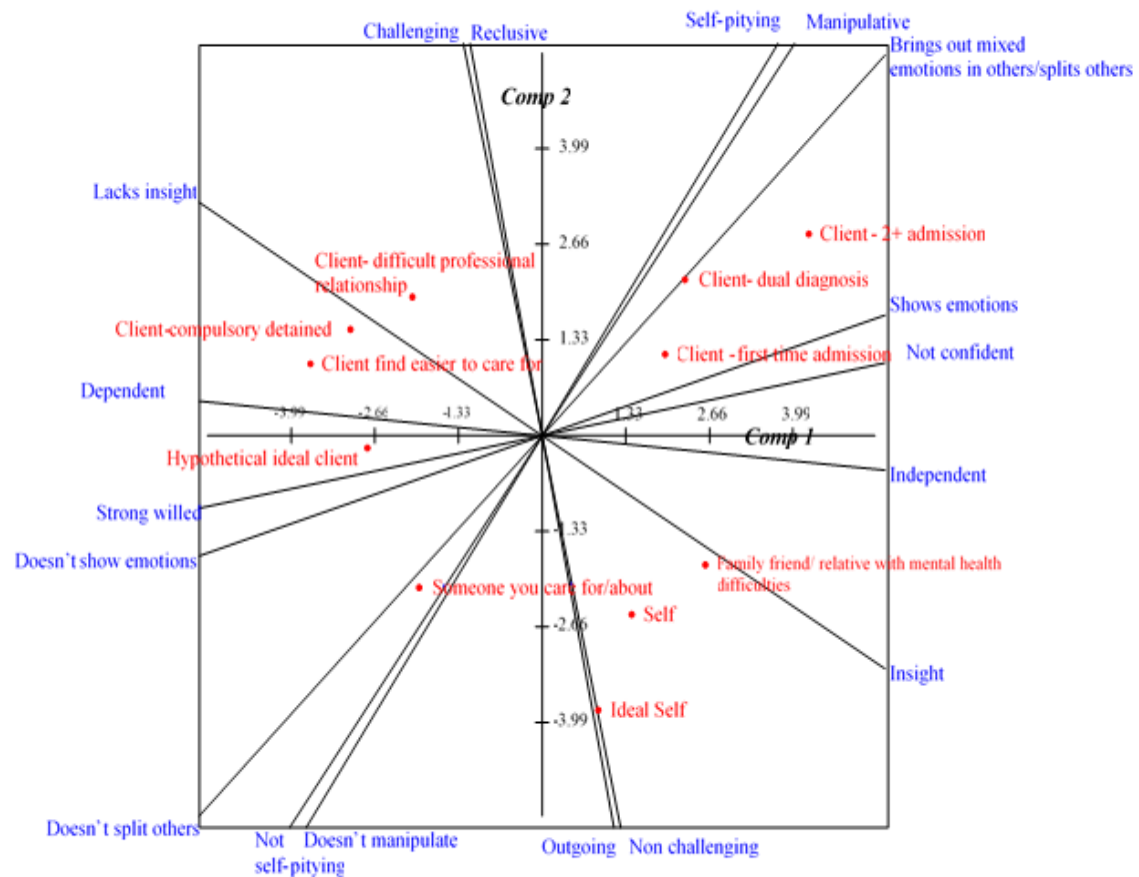
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.77	0									
3	0.91	1.02	0								
4	0.40	0.91	0.96	0							
5	0.53	0.56	1.16	0.72	0						
6	0.35	0.63	0.69	0.60	0.63	0					
7	1.98	1.64	1.32	1.92	1.99	1.78	0				
8	0.49	0.72	0.96	0.28	0.66	0.60	1.77	0			
9	0.49	0.60	0.96	0.75	0.35	0.45	1.92	0.75	0		
10	0.66	0.56	1.05	0.77	0.40	0.63	1.87	0.72	0.35	0	
11	0.49	0.66	1.14	0.69	0.20	0.60	2.06	0.69	0.28	0.35	0

Participant 6:

Eigenvalues:

- Component 1 accounts for 38.94% of the variance
- Component 2 accounts for 25.50% of the variance
- Component 3 accounts for 15.70% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

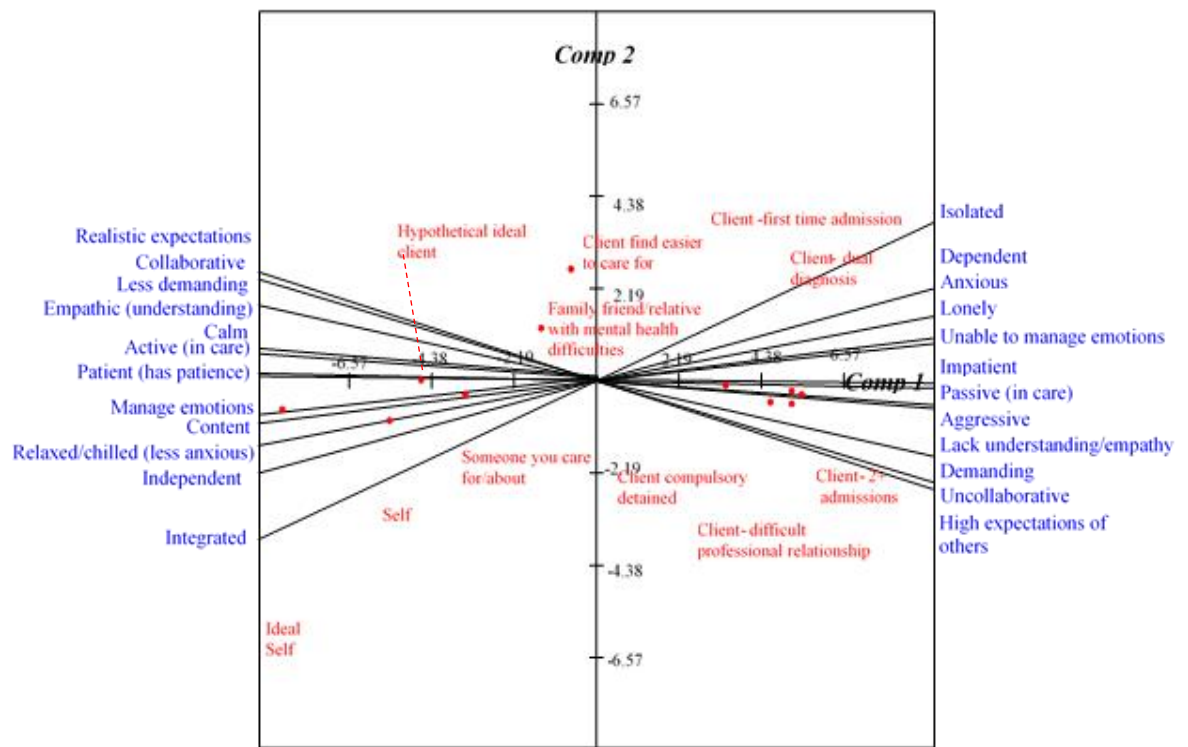
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.85	0									
3	0.68	0.51	0								
4	1.07	1.38	1.04	0							
5	0.98	1.41	1.08	0.77	0						
6	1.10	1.30	1.00	0.66	0.85	0					
7	0.92	1.19	0.90	0.70	0.82	0.32	0				
8	0.75	0.96	0.75	1.16	1.13	1.17	1.05	0			
9	1.21	1.35	1.15	0.77	1.04	1.07	1.18	1.08	0		
10	0.85	1.09	0.88	1.14	1.03	0.98	0.92	0.45	1.03	0	
11	0.99	1.27	1.07	1.20	1.00	1.10	1.08	0.64	0.98	0.32	0

Participant 7:

Eigenvalues:

- Component 1 accounts for 91.67% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

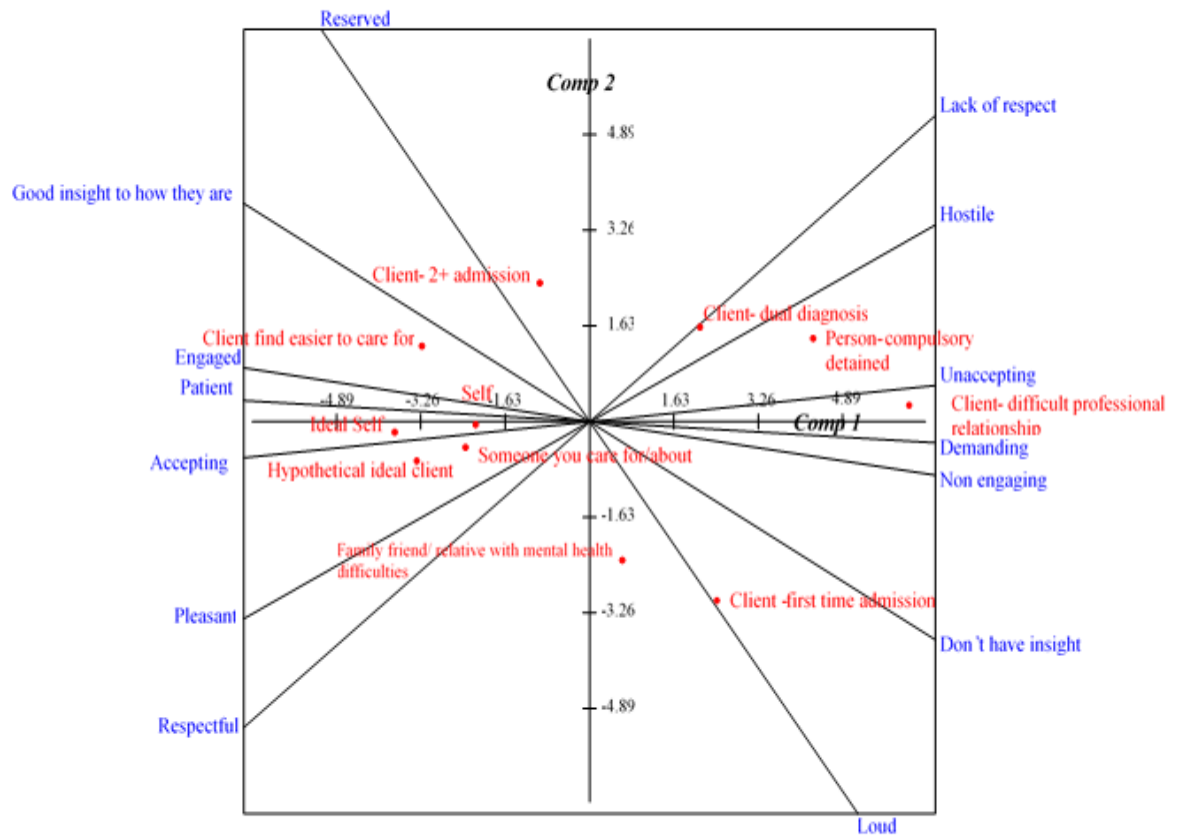
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.33	0									
3	0.36	0.13	0								
4	0.68	0.89	0.92	0							
5	1.11	1.34	1.38	0.66	0						
6	0.33	0.27	0.23	0.85	1.27	0					
7	0.33	0.19	0.13	0.91	1.34	0.27	0				
8	0.75	0.94	0.97	0.30	0.55	0.88	0.94	0			
9	0.99	1.20	1.22	0.60	0.33	1.11	1.19	0.40	0		
10	1.22	1.45	1.48	0.82	0.30	1.39	1.45	0.66	0.45	0	
11	1.61	1.83	1.86	1.13	0.55	1.76	1.83	0.97	0.70	0.42	0

Participant 8:

Eigenvalues:

- Component 1 accounts for 70.72% of the variance
- Component 2 accounts for 16.76% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

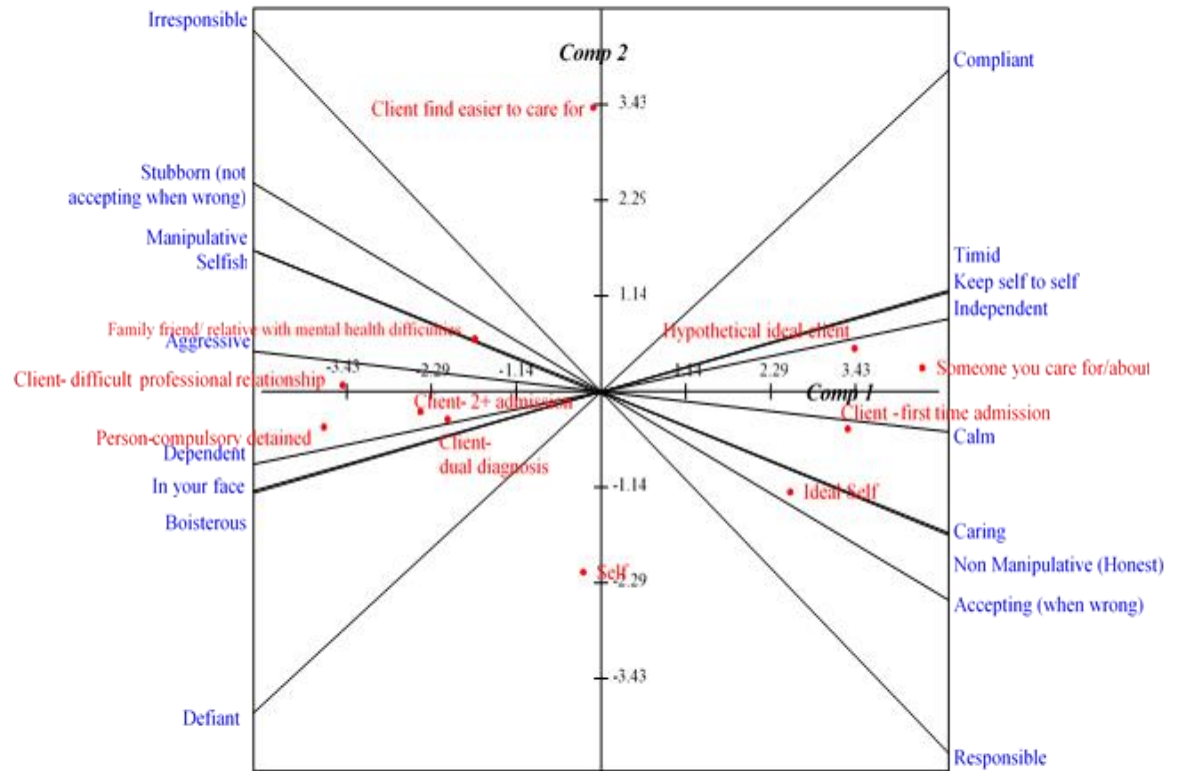
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	1.13	0									
3	0.86	0.61	0								
4	1.27	0.58	1.06	0							
5	1.12	0.76	1.15	0.35	0						
6	0.94	1.06	0.76	1.36	1.42	0					
7	0.93	1.38	0.93	1.67	1.69	0.46	0				
8	0.39	0.87	0.80	0.99	0.82	1.02	1.15	0			
9	1.05	0.74	1.05	0.52	0.46	1.25	1.55	0.76	0		
10	1.02	0.61	0.93	0.46	0.46	1.22	1.51	0.72	0.25	0	
11	1.21	0.74	1.16	0.30	0.17	1.47	1.75	0.91	0.43	0.43	0

Participant 9:

Eigenvalues:

- Component 1 accounts for 67.57% of the variance
- Component 2 accounts for 14.59% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

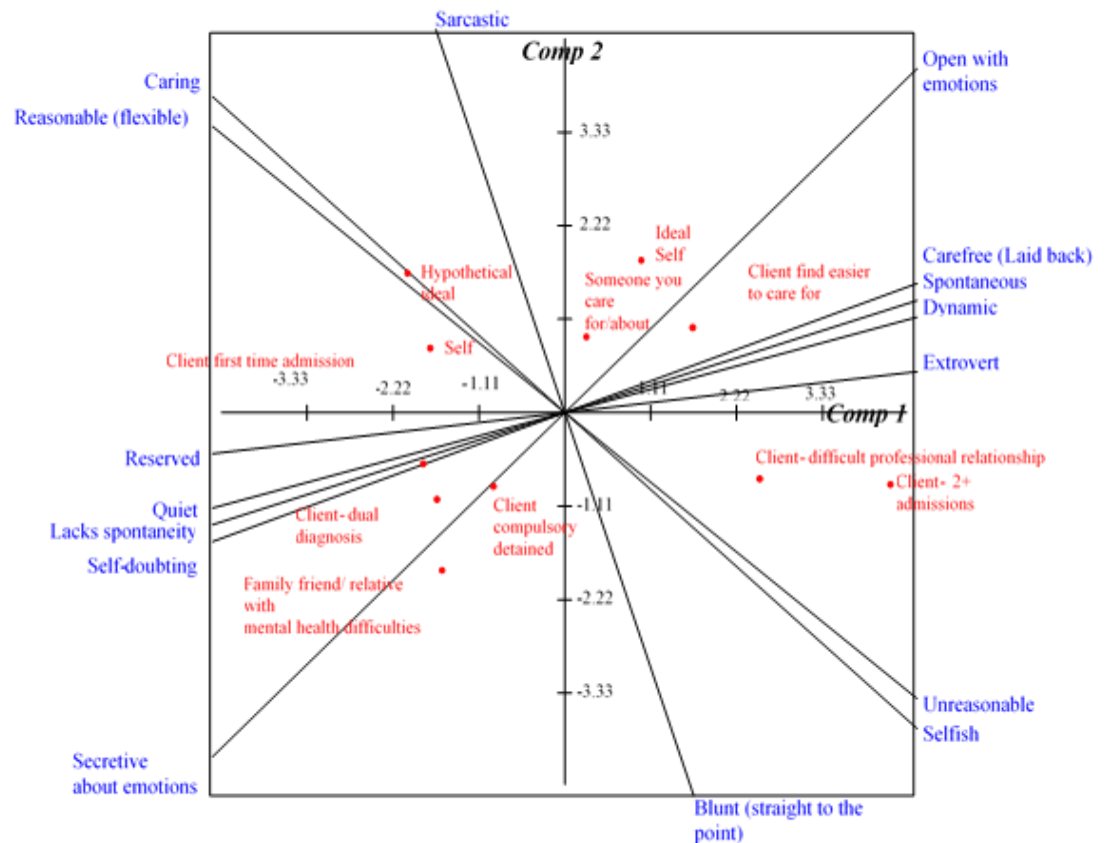
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	1.26	0									
3	1.18	0.20	0								
4	1.09	0.88	0.86	0							
5	0.68	1.23	1.15	1.02	0						
6	1.46	0.56	0.52	1.15	1.46	0					
7	1.42	0.34	0.39	0.98	1.39	0.34	0				
8	1.16	0.39	0.34	0.73	1.02	0.56	0.44	0			
9	0.76	1.36	1.29	1.15	0.44	1.69	1.58	1.24	0		
10	1.04	0.65	0.62	1.13	1.08	1.06	0.92	0.81	1.09	0	
11	0.48	1.09	1.00	1.13	0.48	1.26	1.24	0.94	0.71	0.88	0

Participant 10:

Eigenvalues:

- Component 1 accounts for 62.12% of the variance
- Component 2 accounts for 21.70% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

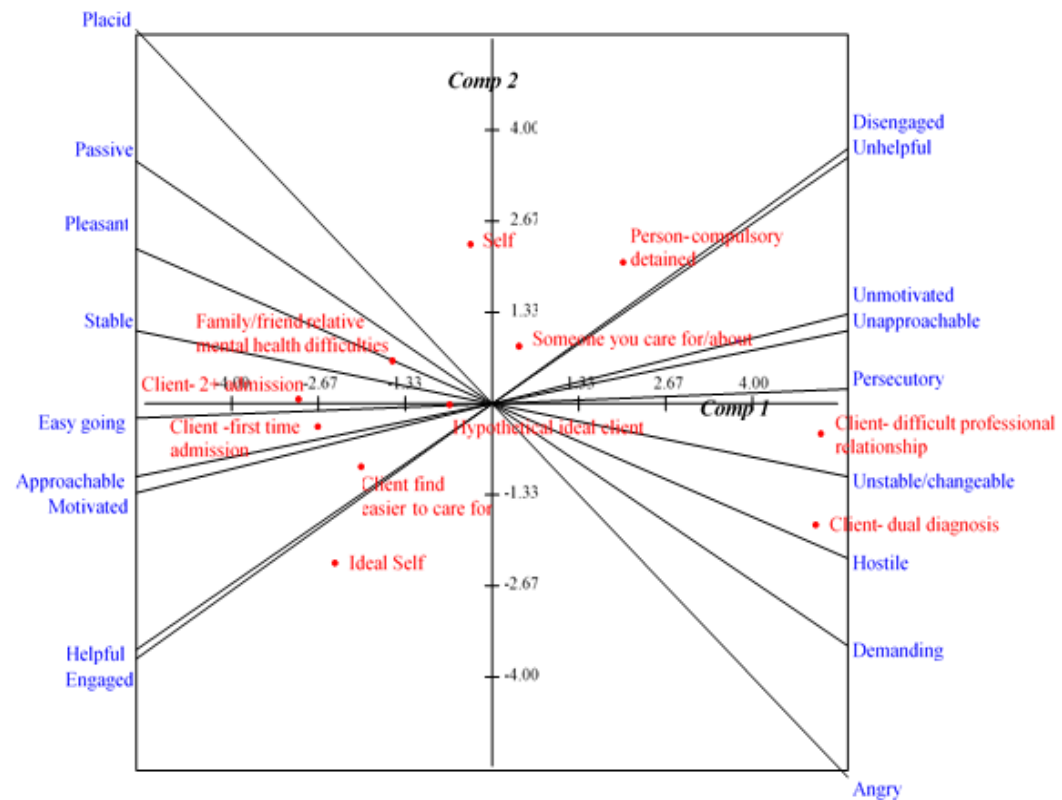
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	1.63	0									
3	0.46	1.60	0								
4	1.06	0.91	1.09	0							
5	0.79	1.81	0.91	1.15	0						
6	0.53	1.40	0.46	0.91	0.88	0					
7	1.24	0.53	1.21	0.75	1.37	0.99	0				
8	0.46	1.56	0.53	1.21	0.99	0.46	1.15	0			
9	0.83	1.18	0.88	0.53	0.88	0.65	0.91	0.95	0		
10	0.59	1.65	0.75	1.02	0.53	0.59	1.27	0.75	0.59	0	
11	1.02	1.15	1.06	0.46	0.91	0.95	0.88	1.24	0.59	0.91	0

Participant 11:

Eigenvalues:

- Component 1 accounts for 63.42% of the variance
- Component 2 accounts for 15.66% of the variance
- Component 3 accounts for 12.13% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

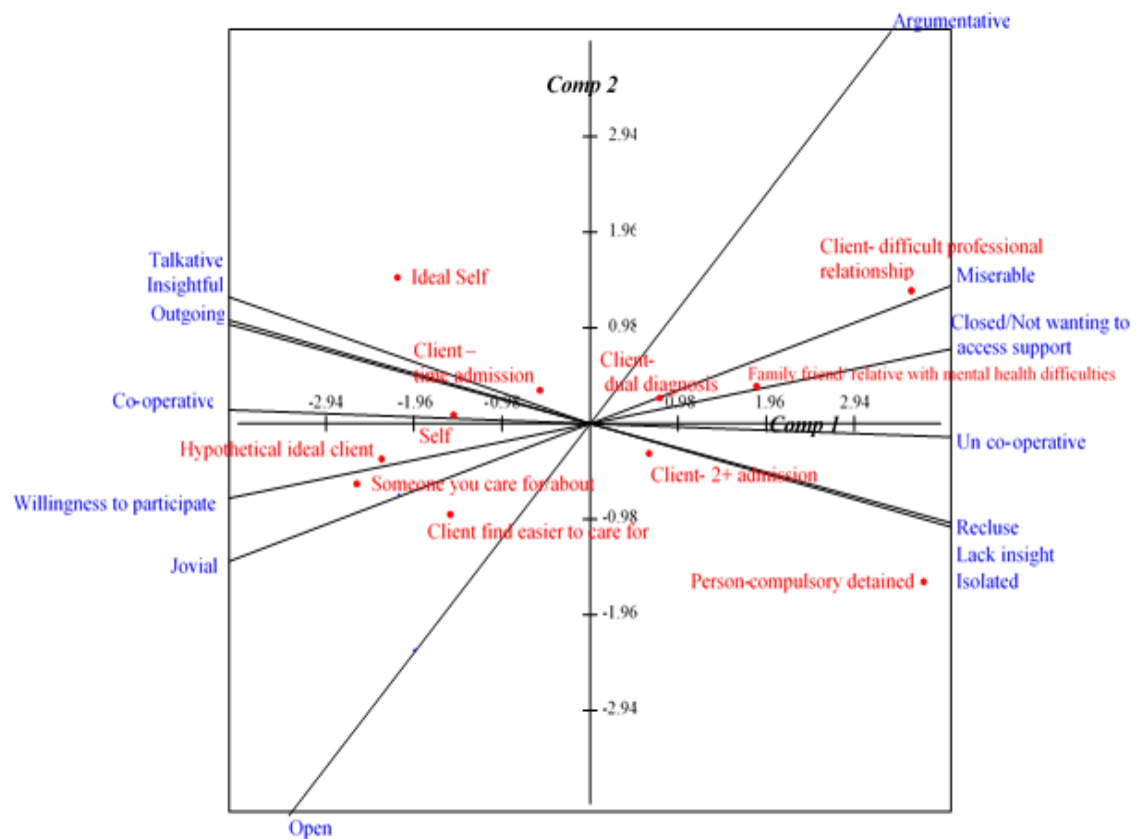
	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.19	0									
3	1.55	1.61	0								
4	0.28	0.34	1.42	0							
5	0.48	0.52	1.15	0.48	0						
6	1.12	1.10	1.03	1.05	0.80	0					
7	1.52	1.58	0.39	1.39	1.15	0.87	0				
8	0.44	0.39	1.38	0.52	0.34	0.87	1.35	0			
9	0.89	0.87	1.10	0.85	0.52	0.73	1.07	0.62	0		
10	0.93	0.91	1.38	0.93	0.65	0.83	1.29	0.78	0.55	0	
11	0.85	0.83	1.53	0.75	0.80	1.35	1.63	0.91	0.91	1.07	0

Participant 12:

Eigenvalues:

- Component 1 accounts for 71.40% of the variance
- Component 2 accounts for 11.49% of the variance

Pingrid



Distance between elements (standardised element Euclidean distances)

	1	2	3	4	5	6	7	8	9	10	11
1	0										
2	0.45	0									
3	0.78	0.74	0								
4	0.45	0.64	0.90	0							
5	0.58	0.82	0.97	0.37	0						
6	1.33	1.01	1.07	1.45	1.66	0					
7	1.13	0.90	0.97	1.47	1.60	0.86	0				
8	0.74	0.45	0.69	1.01	1.13	0.82	0.58	0			
9	0.74	0.94	1.01	0.45	0.26	1.68	1.70	1.22	0		
10	0.58	0.74	0.90	0.52	0.52	1.45	1.42	0.94	0.45	0	
11	0.74	1.01	1.01	0.78	0.69	1.72	1.54	1.16	0.64	0.45	0

Appendix K: Content analysis results

Classification System for Personal Construct (CSPC) analysis categories	
Category	Number of constructs (%)
Moral	23 (22.3%)
Altruistic-egoist	14 (61%)
Respectful-judgemental	2 (9%)
Sincere-insincere	6 (26%)
Responsible- irresponsible	1 (4%)
Emotional	13 (12.7%)
Visceral-Rational	3 (23%)
Optimist - pessimist	1 (7.5%)
Warm-cold	4 (31%)
Balanced - unbalanced	4 (31%)
Specific emotions	1 (7.5%)
Relational	42 (40.7%)
Peaceable- aggressive	10 (24%)
Extroverted-introverted	16 (38%)
Dependent- Independent	5 (12%)
Conformist-rebel	6 (14%)
Trusting- suspicious	2 (5%)
Direct- devious	1 (2%)
Sympathetic – unsympathetic	2 (5%)
Personal	20 (19.4%)
Other	2 (10%)
Flexible – Rigid	5 (25%)
Hardworking-lazy	5 (25%)
Thoughtful- shallow	2 (10%)
Self-acceptance- Self-criticism	3 (15%)
Active – Passive	2 (10%)
Mature – immature	1 (5%)
Intellectual/operational	4 (3.9%)
others	3 (75%)
Focused-unfocused	1 (25%)
Existential	1 (1%)
Purposeful- purposeless	1 (100%)
	Total 103 (100%)