Harmful experiences during psychiatric admission.

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Background

In all Western European counties, psychiatric care is changing. Over the last decades, institutionalized care is more and more replaced by community-centred outpatient care (Priebe et al., 2008). However, despite the reduction of beds in psychiatric hospitals, the number of involuntary admissions in most European countries is rising (Priebe et al., 2008; Schoevaerts, Bruffaerts, Mulder & Vandenberghe, 2013). In the Netherlands, in 2009, 80 of 100.000 inhabitants were involuntarily admitted, which was an increase of 25% compared to the year 2002 (Schoevaerts et al., 2013). Involuntarily admitted patients are likely to be admitted to a closed ward. A minority of patients on a closed ward are admitted voluntarily, but a third of the voluntarily admitted patients also feels pressured or persuaded to their admission, or perceives coercion during their admission (Bindman et al., 2005, Sorgaard, 2007, Katsakou et al. 2011, O'Donoghue et al., 2014). Furthermore, voluntarily admitted patients are usually subjected to the restrictions associated with a closed ward (Poulsen, 1999).

Admission to a closed psychiatric acute ward can be harmfully due to various factors. At first, coercive measures like seclusion, forced medication and restrictions on leaving the ward can cause stress and burden . In recent years, the reduction of coercion in psychiatric care has been very important in Europe (Council of Europe, 2000). In the Netherlands, the number of seclusions in the Netherlands is slightly decreasing, as is the use of forced medication. Regarding the duration of seclusions, the trend is more clearly downwards (GGZ Nederland, 2012). Research into the numbers of coercive measures in different countries is still very limited (Steinert et al., 2010) and empirical evidence on the effectiveness of coercive measures is scarce (Sailas & Fenton, 2000, Nelstrop et al., 2006). However, qualitative studies found coercive measures to have serious adverse effects, like being dehumanized or being unheard (Hoekstra, Lendemeijer & Jansen, 2004; Meehan, Vermeer & -Windsor, 2000; Moran et al., 2009, Längle et al.2003, and Newton-Howes & Mullen, 2011).

Besides coercive measures, there are other harmful experiences that may occur during psychiatric admission (Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennet, 2003, Tarrier, Khan, Cater, & Picken, 2007). Examples are being patronized by the staff (Sorgaard, 2007), being confronted with the seclusion or restraint of other patients (Iversen, Hoyer, & Sexton, 2007) and being around aggressive patients (Johansson & Lundman, 2002, Robins, Sauvageot, Cusack , Suffoletta-Maierle, & Frueh, 2005). Robins et al. (2005) described these experiences as "Sanctuary Harm". Their findings are that harmful experiences are often

overlooked in research about psychiatric treatment. Thereby, only a minority of patients reports being asked about these experiences (Cusack et al., 2003). Cusack et al. (2003) and Frueh et al. (2005) developed the Psychiatric Experiences Questionnaire to study life-time exposure to harmful experiences that may occur during psychiatric admission. Frueh et al. (2005) found a third of the patients to be physically assaulted, two thirds to have witnessed traumatic events and more than half of the patients had been around frightening or violent patients. Patients who experienced traumatic events earlier in life, reported an increased burden on traumatic events during admission according to Frueh et al.(2005). This is of particular importance because Grubaugh (2011) and Maniglio (2009) found trauma to be highly prevalent in patients with severe mental illness. Frueh et al. (2005) did not found age nor gender to be associated with reported burden. No studies regarding associations between burden and other variables were found. Bindman et al. (2005) found diagnosis to be associated with perceived coercion. In this study patients with psychotic disorders felt more coerced than other patients. Tarrier et al. (2007) found first admissions of psychotic patients to cause severe trauma, but no comparison was made between first admitted patients and patients who had been admitted earlier. This may suggest that first admissions and diagnosis are associated with experienced burden.

Overall, psychiatric treatment on a closed acute ward can be harmful and cause burden. Different studies suggest that harmful experiences during admission, will negatively influence the future functioning of psychiatric patients and their willingness to participate in future treatment (Steinert, Bergbauwer, Schmid, & Gebhardt, 2007, Cusack et al., 2003, Robins et al., 2005). In general, psychiatric nurses are the professionals who are closest to the psychiatric patients and spend most time with admitted patients. Therefore, especially nurses need knowledge about the experiences of patients on an acute ward. They need to know how harmful these experiences are and what factors are associated with the reported burden, in order to prevent harmful experiences or decrease the burden cause by harmful experiences. Besides, more positive perceptions of patients towards psychiatric care can help facilitating future treatment.

Problem statement

Admission to a closed psychiatric acute ward can cause burden. Research into harmful experiences during admission to a closed psychiatric ward and the factors associated with these burden is scarce. Different studies suggest that harmful experiences during admission, will negatively influence the future functioning of psychiatric patients and their willingness to

participate in future treatment. Therefore, insight in the prevalence of harmful experiences and the burden they cause is needed to be able to prevent harmful experiences, to decrease the patients burden and to facilitate future treatment.

Aim

The aim of this study is to explore psychiatric patients' burden, caused by harmful experiences during their admission on a closed acute ward.

Research question

What is the prevalence of harmful experiences during psychiatric admission on a closed ward, how much burden do these experiences cause and what factors are associated with these burden?

Method

Design

A cross-sectional observational explorative study was conducted among patients on closed psychiatric acute wards. This design is appropriate for a descriptive study (Bouter, Dongen, & Zielhuis, 2010, p.86) and chosen because it offers the opportunity to examine the prevalence of experiences and to examine associations between experiences and confounding or intermediating factors. This study is a sub study in a larger study into the traumatic effects of coercive measures on psychiatric patients. The study was approved by a medical ethics committee and by the board of directors from the participating hospitals.

Setting and subjects

The target population consists of all voluntarily or involuntarily admitted adult patients to a closed psychiatric acute ward. Patients with insufficient command of the Dutch language to answer the interview questions were excluded. By the objective of the larger study into the effects of coercive measures, all included patients were subjected to seclusion, forced medication or restrictions on leaving the ward. Patients were recruited from five closed acute wards from two psychiatric hospitals in the western Netherlands.

Instruments/parameters

The outcome variables of this study of this study are the frequencies of harmful experiences on a closed acute ward and the burden these experiences cause. To examine associations between reported burden and other variables, the dependent variables are the burden on the most frequent mentioned experiences. Independent variables are the main diagnosis (psychotic disorder, yes/no, dichotomous), previous admissions (yes/no, dichotomous) and number of traumatic events earlier in life (continuous).

The instrument used in this study to measure the frequencies of harmful experiences and the burden they cause is the Psychiatric Experiences Questionnaire (PEQ). The PEQ is a 29-item questionnaire developed by Cusack et al. (2003) and Frueh et al. (2005), designed to assess for a wide range of harmful experiences related to psychiatric admission, ranging from “being threatened with physical violence” or “being deprived of adequate food or nutrition” to “witnessing the death of another person while in the psychiatric setting”. The questionnaire was developed from focus groups and preliminary tested and refined in a pilot study (Cusack et al., 2003). For each experience, the patient is asked if he experienced this item and how much burden this experience is causing on a five-point scale (1=very little, 2=little, 3=reasonable, 4=much, 5=extreme). In the Dutch version of the PEQ, one coercive measure (restrictions on leaving the ward) and three other experiences (being transported in an ambulance, witnessing self-mutilation of a fellow patient and suicide attempt by fellow patient) were added to the questionnaire, which resulted in a total of 33 experiences. No psychometric properties of the PEQ are known.

The instrument used in this study to assess for traumatic events earlier in life is the LEC-4. The LEC-4 is a 19-item questionnaire to screen for life-time exposure to potential traumatizing events. It was developed at the National Center for PTSD concurrently with the Clinician Administered PTSD Scale (CAPS) to assess exposure to potentially traumatic events (Gray, Litz, Hsu, & Lombardo, 2004). For each event, the patient is asked if he experienced it himself, witnessed it or heard of it. The LEC-4 has demonstrated adequate psychometric properties to assess for trauma exposure (Gray et al., 2004).

Procedures/data collection

Patients were recruited at the moment they were no longer restricted to leave the ward. All patients received information about the study, both verbally and in written. After signing informed consent, a number of general questions about patient characteristics were asked. Next, the Psychiatric Experiences Questionnaire (PEQ, appendix 1) and the Life Events Checklist (LEC, appendix 2) were administered. Data on diagnosis and earlier admissions were retrieved from the patients’ records. The questions of the PEQ concerned the present admission, the questions of the LEC life-time exposure to traumatic events. Convenience

sampling was used. At random moments, all eligible patients were recruited. When there were more patients eligible than the number that could be a approached that day, patients were randomly selected. For this random selection of patients we used the room numbers of the patients. On the first day we started top to bottom and vice versa the next day. The duration of the study was five months.

Analysis and sample-size

Descriptive analyses were conducted to describe the patient characteristics, the frequencies and mean burden of experiences of the PEQ and the frequencies of events of the LEC that patients experienced themselves (or, for the item “sudden death” witnessed it). Separate multiple linear regression analyses (up to three) were conducted to examine the association between the burden on the most frequent reported experiences of the PEQ (dependent variable) and diagnosis, previous admissions and number of events on the LEC-4 (independent variables). For each analysis (with 3 variables), at least 30 patients who reported the experience were needed (Twisk, 2010, p.244). Therefore the sample-size was determined to be at least above 40. All data were analyzed using SPSS 20.0 for Windows, with an alpha level set to 0.05.

Results

Participants

Initially, of the 141 eligible patients, 98 patients were randomly selected. Of these patients 26 were not present at the ward and could not be approached. From the 72 patients that were approached, 29 refused to cooperate, so 43 patients were included. The characteristics of the participants are presented in Table 1. No significant differences between participants and non-participants were found on gender and age, but diagnosis and legal status differed significantly. Patients who refused to cooperate were more often involuntarily admitted (p=.039) and suffered more often from psychotic disorders (p= .001).

Exposure to psychiatric experiences and life events

Table 2 and 3 show the frequencies and percentages on all the experiences of the PEQ and the mean burden per experience with the SD. Table 2 presents the experiences from highest to lowest frequency and Table 3 presents the experiences from highest burden to lowest burden. The percentage of the coercive measures found is: seclusion (56%), forced medication (30%) and restrictions on leaving the ward (95%). Apart from the coercive

measures, all patients reported at least one other harmful experience during their admission. The mean number of harmful experiences reported is 8.6 (SD=4.8 and a range from 3 to 26). The most reported harmful experiences were “being around other patients who were very violent or frightening in other way” (74%),” witnessing any form of self-mutilation of another patient” (40%),”being taken down by police or psychiatric staff” (40%), and ”not having adequate privacy for bathing, dressing, or using the toilet” (40%). “Other experiences, not part of the PEQ” were reported by 63% of the participants. Examples are the communication with staff, attitude of the staff, screaming and cursing by fellow patients, and a hectic and noisy environment. The results of events the LEC are presented in Table 4. The average number of events on the LEC is 5.3 (SD 3.1), with a range from 0 to 14. Physical assault is reported most, by two thirds of the participants. Sexual assault is reported by one third of the participants.

Burden caused by psychiatric experiences

The highest reported burden found in this study was caused by “experiencing a staff member using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting” (5.0), “witnessing another patient being sexually assaulted by a staff member” (4.0), “being handcuffed and transported in a police car” (4.0), “experiencing staff calling you names or bullying you in some other verbal way”(3.5), witnessing the death of another person while in the psychiatric setting” (3.5), “having medication used as a threat or punishment” (3.4), “being deprived of adequate food or nutrition” (3.4), and “not having adequate privacy for bathing, dressing, or using the toilet” (3.3). The burden of “other experiences” was rated 3.5. The burden caused by coercive measures was the lowest for “being placed in seclusion” (2.4), followed by “restrictions on leaving the ward” (2.5) and the highest for “being forced to take medication against your will” (3.1).

Statistical analysis

The harmful experiences reported over 30 times were “restrictions on leaving the ward” and ”being around other patients who were very violent or frightening”. Both these variables were not normally distributed. Instead of an association model, non-parametric tests (Mann-Whitney tests) for each independent variable were done. The variable “number of events on the LEC” was dichotomized to perform a Mann-Whitney tests (< 6 events experienced and 6 or more, a cut-off between 5 and 6 was chosen because the mean was 5.3 and the median 5.0). No significant differences on the burden caused by “restrictions on leaving the ward” were found regarding previous admissions, diagnosis and number of events on the LEC. The burden caused by ”being around other patients who were very violent or frightening” showed

no significant differences regarding diagnosis or number of events on the LEC. However, there was a significant difference between first admitted patients and patients who were earlier admitted. First admitted patients reported a mean burden of 1.71 and patients who were earlier admitted reported a mean burden of 2.95 (p=.023).

Discussion

The findings of this study show that patients report high rates of harmful experiences during psychiatric admission, with a mean number of 8.6. The high number of participants who experienced coercive measures is due to the fact that participants were recruited on a closed acute ward. The experiences that were causing the highest burden and occurred more than once or twice are “being deprived of adequate food or nutrition” , “experiencing staff calling you names or bullying you in some other verbal way”, “being handcuffed and transported in a police car” and “having medication used as a threat or punishment”. Patients reported relatively low burden on coercive measures. In all harmful experiences, SD’s and thus individual differences are large. Associations between the burden found on the two most frequent reported experiences only show a significant association between the experienced burden on “being around other patients who were very violent or frightening” and previous admissions.

A strength of this study is that it is conducted at multiple sites and patients were randomly selected. However, there are also some limitations. First, our study was limited by the small sample size, which influences the generalizability of this study. Second, the patients who refused to cooperate in this study were more often involuntarily admitted and they suffered more often from psychotic disorders. This also influences the generalizability of this study. Third, because the questionnaires were taken retrospectively, there is a risk of recall bias. At last, many patients were not sufficiently stabilized to be recruited and might have left the acute ward with restrictions on leaving the ward. These patients are more likely to have been coerced during their admission or to have been more affected by what happened to them. Our rates of exposure to coercion and experienced burden might have been underestimated.

Our findings confirm and extend the findings of Frueh et al. (2005), Cusack et al. (2003) and Ladois-Do Pilar Rei et al. (2012) that psychiatric admission is accompanied by harmful experiences that cause burden to patients. Our findings that over 70% of the patients reported to have been around aggressive patients confirms the findings of Kuosmanen, Hätönen, Malkavaara, Kylmä, & Välimäki (2007) and Stenhouse (2013) that patients do not feel safe on a ward because of the threat of other patients. Apart from the harmful

experiences during admission, we found patients to report high rates of traumatic life events. Just as in the criminal victimization study of Kamperman et al. (2014), physical and sexual assault were highly prevalent.

The relatively low burden we found on seclusion, contradicts with the high burden Frueh et al. (2005) found on seclusion. This low burden on seclusion also contradicts with the findings of Georgieva, Mulder & Wierdsma (2012), who found that 62% of the patients who were secluded and forcibly medicated, preferred forced medication in future emergencies. Possible explanations are the decrease in the use of seclusion over the last years and the fact that the secluded patients in our study may partly have agreed to being secluded. Georgieva et al. (2012) found that patients who approved to the duration of their seclusion, would chose to being secluded in future emergencies. Hughes, Hayward & Finlay (2009) found that patients who perceive their relations with the staff as coercive and punitive, were confirmed in their negative self-concepts and it increased their distress. This confirms our findings that patients reported the highest burden on experiences related to patient-staff interactions ("being deprived of adequate food or nutrition", "experiencing staff calling you names or bullying you in some other verbal way" and "having medication used as a threat or punishment").

Our findings that first admitted patients report a lower burden on "being around other patients who were very violent or frightening" than patients who were admitted earlier, seem illogical and are hard to explain. Perhaps first admitted patients were still so overwhelmed by all the new impressions, that they had not yet began to realize how the experiences affected them. In any case, our findings are not in accordance with the findings of Tarrier et al. (2007). They included 35 patients who suffered their first psychotic episode and found two thirds to have been severely traumatized by being hospitalized. Nine percent of the patients reported as main reason for being traumatized their fear of other patients. It is difficult to compare this study to our study, because we did not solely include patients with psychosis. Besides, there were only seven patients admitted for the first time.

Conclusion

Our findings show that psychiatric admission on a closed ward is often accompanied by harmful experiences. Nurses play a role in the emergence of burden caused by these harmful experiences. Nurses might therefore be able to prevent harmful experiences or give the aftercare patients need in order to preclude that psychiatric treatment in itself is traumatizing.

Recommendations

The experiences with the highest reported burden are almost all related to the contact between patients and staff/nurses. Nurses might therefore be able to prevent the occurrence of harmful experiences, or decrease the burden they cause. To do so, they have to become more aware of what patients perceive to be harmful. Not only the use of coercive measures should be reduced, but extra attention is needed for all harmful experiences during psychiatric admission. If experiences are not preventable, nurses can also help to decrease the experienced burden, by providing aftercare and give patients the opportunity to express their feelings. For example, being around aggressive patients was often reported in our study. The experience of safety on the closed ward is very important and more attention for the patients' safety is needed. As being in a closed ward is distressing enough in itself, patients should not be frightened for other patients during their admission. Decreasing the burden patients experience during admission will benefit patients' well-being, but also the patients' motivation to be treated in the future (and thus treatment outcomes). Additionally, when determining policy and developing nursing practice, patient experiences need to be given a central role.

The results provide strong evidence for the need to further examine burdening experiences on a locked ward. Studies with more participants are needed to extend the knowledge found in this study. Future research about how these events influence treatment outcomes/adherence is recommended. Also, variables that are associated with experienced burden need further research.

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Tables

Table 1 Demographic and clinical characteristics N=43

	N (%)
Gender	
Male	23 (54)
Female	20 (47)
Age	
18-30	16 (37)
31-50	16 (37)
51-65	11 (26)
Dutch native	
Yes	23 (54)
No	4 (44)
Missing	1 (2)
Living conditions	
Alone	15 (35)
With parents	7 (16)
With partner/children	9 (21)
Homeless	2 (5)
Other	9 (21)
Education	
Low	13 (31)
Average	18 (42)
High	7 (16)
Other	4 (9)
Employment	
Employed	8 (19)
Unemployed	34 (79)
Missing	1 (2)
Primary diagnosis	
Psychotic disorder	21 (49)
Mood disorder	17 (40)
Personality disorder	3 (7)
Other	2 (5)
Legal status	
Voluntary	20 (47)
Involuntary	21 (49)
Missing	2 (5)
Previous admissions	
Yes	29 (67)
No	7 (16)
Missing	7 (16)

Table 2 Results of the Psychiatric Experiences Questionnaire (N=43), high to low frequency

Items of the PEQ	**N (%)**	**Mean burden (SD)**
Restrictions on leaving the ward	41 (95)	2.5 (1.5)
Being around other patients who were very violent or frightening in other way	32 (74)	2.7 (1.4)
A burdening experience not mentioned above	27 (63)	3.5 (1.5)
Being placed in seclusion	24 (56)	2.4 (1.4)
Being “taken down” by police or psychiatric staff	17 (40)	2.9 (1.7)
Witnessing any form of self-mutilation of another patient	17 (40)	1.9 (0.9)
Not having adequate privacy for bathing, dressing, or using the toilet	17 (40)	3.3 (1.5)
Being transported in an ambulance	16 (37)	2.1 (1.6)
Being forced to take medication against your will	13 (30)	3.1 (1.7)
Witnessing another patient being “taken down”	13 (30)	2.2 (1.6)
Having commitment used as a threat or punishment	13 (30)	2.9 (1.3)
Experiencing a suicide attempt of another patient	12 (30)	2.3 (1.3)
Witnessing another patient being physically assaulted by another patient	11 (26)	2.5 (1.5)
Being deprived of adequate food or nutrition	11 (26)	3.4 (0.3)
Being strip-searched	10 (23)	2.1 (1.1)
Having medication used as a threat or punishment	10 (23)	3.4 (1.4)
Experiencing staff calling you names or bullying you in some other verbal way	10 (23)	3.5 (1.7)
Being threatened with physical violence	10 (23)	2.8 (1.8)
Experiencing unwanted sexual advances while in the psychiatric facility (talking to you about having sex, touching your body)	8 (19)	2.5 (1.6)
Witnessing staff calling other patients names or bullying others in some other verbal way	7 (16)	2.1 (1.2)
Witnessing a staff member being physically assaulted by a patient	6 (14)	2.2 (1.5)
Being handcuffed and transported in a police car	5 (12)	4.0 (1.0)
Experiencing any other form of excessive physical force	4 (9)	2.8 (2.1)
Witnessing another patient being sexually assaulted by another patient	4 (9)	3.0 (1.8)
Experiencing a physical assault (hit, punched, kicked) by a staff member while in the psychiatric facility	4 (9)	2.8 (1.7)
Being put in restraints of any kind	4 (9)	1.5 (1.0)
Experiencing a physical assault (hit, punched, kicked) by another patient while in the psychiatric facility	2 (5)	3.0 (2.8)
Witnessing another patient being physically assaulted by a staff member	2 (5)	2.0 (1.4)
Experiencing another patient using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting	2 (5)	2.5 (2.1)
Witnessing the death of another person while in the psychiatric setting	2 (5)	3.5 (2.1)

Items of the PEQ	N (%)	Mean burden (SD)
Engaging in any type of consensual sexual activity with another patient while in the psychiatric setting	2 (5)	1.0 (0.0)
Engaging in any type of consensual sexual activity with a staff member while in the psychiatric setting	1 (2)	1.0 (0.0)
Experiencing a staff member using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting	1 (2)	5.0 (0.0)
Witnessing another patient being sexually assaulted by a staff member	1 (2)	4.0 (0.0)

Table 3 Results of the Psychiatric Experiences Questionnaire (N=43), high to low burden

Items of the PEQ	**N (%)**	**Mean burden (SD)**
Experiencing a staff member using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting	1 (2)	5.0 (0.0)
Being handcuffed and transported in a police car	5 (12)	4.0 (1.0)
Witnessing another patient being sexually assaulted by a staff member	1 (2)	4.0 (0.0)
Experiencing staff calling you names or bullying you in some other verbal way	10 (23)	3.5 (1.7)
Witnessing the death of another person while in the psychiatric setting	2 (5)	3.5 (2.1)
A burdening experience not mentioned above	27 (63)	3.5 (1.5)
Having medication used as a threat or punishment	10 (23)	3.4 (1.4)
Being deprived of adequate food or nutrition	11 (26)	3.4 (0.3)
Not having adequate privacy for bathing, dressing, or using the toilet	17 (40)	3.3 (1.5)
Being forced to take medication against your will	13 (30)	3.1 (1.7)
Experiencing a physical assault (hit, punched, kicked) by another patient while in the psychiatric facility	2 (5)	3.0 (2.8)
Witnessing another patient being sexually assaulted by another patient	4 (9)	3.0 (1.8)
Being “taken down” by police or psychiatric staff	17 (40)	2.9 (1.7)
Having commitment used as a threat or punishment	13 (30)	2.9 (1.3)
Experiencing any other form of excessive physical force	4 (9)	2.8 (2.1)
Being threatened with physical violence	10 (23)	2.8 (1.8)
Experiencing a physical assault (hit, punched, kicked) by a staff member while in the psychiatric facility	4 (9)	2.8 (1.7)
Being around other patients who were very violent or frightening in other way	32 (74)	2.7 (1.4)
Restrictions on leaving the ward	41 (95)	2.5 (1.5)
Witnessing another patient being physically assaulted by another patient	11 (26)	2.5 (1.5)
Experiencing unwanted sexual advances while in the psychiatric facility (talking to you about having sex, touching your body)	8 (19)	2.5 (1.6)
Experiencing another patient using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting	2 (5)	2.5 (2.1)
Being placed in seclusion	24 (56)	2.4 (1.4)
Experiencing a suicide attempt of another patient	12 (30)	2.3 (1.3)
Witnessing another patient being “taken down”	13 (30)	2.2 (1.6)
Witnessing a staff member being physically assaulted by a patient	6 (14)	2.2 (1.5)
Being strip-searched	10 (23)	2.1 (1.1)
Witnessing staff calling other patients names or bullying others in some other verbal way	7 (16)	2.1 (1.2)
Being transported in an ambulance	16 (37)	2.1 (1.6)

Items of the PEQ	N (%)	Mean burden (SD)
Witnessing another patient being physically assaulted by a staff member	2 (5)	2.0 (1.4)
Witnessing any form of self-mutilation of another patient	17 (40)	1.9 (0.9)
Being put in restraints of any kind	4 (9)	1.5 (1.0)
Engaging in any type of consensual sexual activity with another patient while in the psychiatric setting	2 (5)	1.0 (0.0)
Engaging in any type of consensual sexual activity with a staff member while in the psychiatric setting	1 (2)	1.0 (0.0)

Table 4 Results of the LEC (N=43)

Event	N (%)
1 Natural disaster (for example, flood, hurricane, tornado, earthquake)	5 (12)
2 Fire or explosion	10 (23)
3 Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	20 (47)
4. Serious accident at work, home, or during recreational activity	10 (23)
5 Exposure to toxic substance (for example, dangerous chemicals, radiation)	7 (16)
6 Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	29 (67)
7 Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	13 (30)
8 Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	13 (30)
9. Other unwanted or uncomfortable sexual experience	8 (19)
10 Combat or exposure to a war-zone (in the military or as a civilian)	5 (12)
11 Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	7 (16)
12 Life-threatening illness or injury	14 (33)
13 Severe human suffering	21 (49)
14 Sudden violent death (for example, homicide, suicide)	7 (16)
15 Sudden accidental death	17 (40)
16 Serious injury, harm, or death you caused to someone else	3 (7)
17 Seeing dead bodies (for example, a mass grave)	0
18 Mine accident	0
19 Any other very stressful event or experience	23 (54)

Appendix 1 Psychiatric Experiences Questionnaire

Items of the PEQ
1 Being placed in seclusion
2 Being forced to take medication against your will
3 Restrictions on leaving the ward
4 Being handcuffed and transported in a police car
5 Being “taken down” by police or psychiatric staff
6 Witnessing another patient being “taken down”
7 Being put in restraints of any kind
8 Being strip-searched
9 Having medication used as a threat or punishment
10 Having commitment used as a threat or punishment
11 Experiencing any other form of excessive physical force
12 Experiencing staff calling you names or bullying you in some other verbal way
13 Witnessing staff calling other patients names or bullying others in some other verbal way
14 Being deprived of adequate food or nutrition
15 Not having adequate privacy for bathing, dressing, or using the toilet
16 Being around other patients who were very violent or frightening in other way
17 Being threatened with physical violence
18 Experiencing a physical assault (hit, punched, kicked) by a staff member while in the psychiatric facility
19 Experiencing a physical assault (hit, punched, kicked) by another patient while in the psychiatric facility
20 Witnessing another patient being physically assaulted by a staff member
21 Witnessing another patient being physically assaulted by another patient
22 Experiencing unwanted sexual advances while in the psychiatric facility (talking to you about having sex, touching your body)
23 Experiencing a staff member using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting
24 Experiencing another patient using pressure, threats, or force to engage in any type of sexual contact with you in the psychiatric setting
25 Witnessing another patient being sexually assaulted by a staff member
26 Witnessing another patient being sexually assaulted by another patient
27 Witnessing the death of another person while in the psychiatric setting
28 Engaging in any type of consensual sexual activity with another patient while in the psychiatric setting
29 Engaging in any type of consensual sexual activity with a staff member while in the psychiatric setting
30 Witnessing a staff member being physically assaulted by a patient
31 Being transported in an ambulance
32 Witnessing any form of self-mutilation of another patient
33 Experiencing a suicide attempt of another patient
34 A burdening experience not mentioned above

Appendix 2 Life Events Checklist

Event
1 Natural disaster (for example, flood, hurricane, tornado, earthquake)
2 Fire or explosion
3 Transportation accident (for example, car accident, boat accident, train wreck, plane crash)
4 Serious accident at work, home, or during recreational activity
5 Exposure to toxic substance (for example, dangerous chemicals, radiation)
6 Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)
7 Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)
8 Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)
9 Other unwanted or uncomfortable sexual experience
10 Combat or exposure to a war-zone (in the military or as a civilian)
11 Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)
12 Life-threatening illness or injury
13 Severe human suffering
14 Sudden violent death (for example, homicide, suicide)
15 Sudden accidental death
16 Serious injury, harm, or death you caused to someone else
17 Seeing dead bodies (for example, a mass grave)
18 Mine accident
19 Any other very stressful event or experience

Dutch summary

Titel: Belastende gebeurtenissen die patiënten meemaken gedurende hun verblijf op een gesloten opnameafdeling van een psychiatrisch ziekenhuis.

Inleiding: Een opname op een gesloten opnameafdeling van een psychiatrisch ziekenhuis kan erg belastend zijn voor patiënten. Naast de belasting die door dwangmaatregelen wordt veroorzaakt, zijn er ook veel andere belastende gebeurtenissen tijdens een opname. Er is nog weinig onderzoek gedaan naar welke gebeurtenissen belastend zijn voor patiënten en hoeveel last ze veroorzaken.

Doel en onderzoeksvragen: Het doel van deze studie is het onderzoeken welke belastende gebeurtenissen patiënten meemaken tijdens hun verblijf op een gesloten opnameafdeling en hoeveel last zij van deze gebeurtenissen hebben ervaren.

Methode: Dit onderzoek is een cross-sectionele observationele studie, uitgevoerd binnen een groter onderzoek naar de traumatische gevolgen van dwangmaatregelen. De Psychiatric Experiences Questionnaire en de Life Events Checklist zijn afgenomen bij patiënten op gesloten opnameafdelingen.

Resultaten: In dit onderzoek hebben patiënten gemiddeld meer dan acht belastende gebeurtenissen meegemaakt tijdens hun opname. Gebeurtenissen die frequent voorkwamen en als zeer belastend werden ervaren zijn: het ervaren van beperkingen in de toegang tot vocht en/of voeding, uitgescholden of gepest worden door personeel, toediening van medicatie als straf of bedreiging ervaren en het ervaren van een gebrek aan privacy tijdens het wassen, aankleden of op het toilet.

Conclusie: De gebeurtenissen die door patiënten als zeer belastend werden ervaren zijn vooral gebeurtenissen waarbij het contact tussen patiënt en personeel een rol speelt.

Aanbevelingen: Door kennis over welke gebeurtenissen patiënten belastend vinden kunnen verpleegkundigen een belangrijke rol spelen in het voorkomen van deze gebeurtenissen of bij het geven van nazorg bij gebeurtenissen die niet voorkomen kunnen worden. Er is verder onderzoek nodig naar de gevolgen van belastende gebeurtenissen tijdens een opname op latere behandeling en naar de factoren die samenhangen met de ervaren belasting.

Trefwoorden: Psychiatrische opname, belastende gebeurtenissen.

English abstract

Title: Harmful experiences during psychiatric admission.

Background: Admission on a closed acute psychiatric ward can cause burden to patients. This burden can be caused by coercive measures, but also by other harmful experiences during admission. Research into harmful experiences during psychiatric admission, and the burden they cause, is scarce.

Aim: The aim of this study is to explore psychiatric patients' burden, caused by harmful experiences during their admission on a closed acute ward.

Method: This study is a cross-sectional observational study conducted within a larger study into the traumatic effects of coercive measures. Participants were voluntary or involuntary admitted psychiatric patients, who were exposed to seclusion, forced medication or restrictions on leaving the ward. The instruments used in this study are the Psychiatric Experiences Questionnaire and the Life events Checklist.

Results: The findings of this study show that patients report high rates (an average of more than eight) of harmful experiences. Frequent mentioned experiences with the highest reported burden are "experiencing staff calling you names or bullying you in some other verbal way", "being deprived of adequate food or nutrition", "not having adequate privacy for bathing, dressing, or using the toilet" and "having medication used as a threat or punishment".

Conclusion: The most harmful experiences for patients on a closed acute ward are experiences related to the contact between patients and staff.

Recommendations: Through knowledge about which experiences are harmful to patients, nurses can play an important role in preventing these experiences or in providing aftercare for experiences that cannot be eliminated. Future research is needed into the effects of harmful experiences on future treatment and the factors associated with perceived burden. Additionally, in policy and service development, as in developing nursing practice, patient experiences must play an important role.

Keywords: Psychiatric admission, harmful experiences.