Patient experiences with nursing care during a manic episode: a phenomenological study

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Introduction

Bipolar disorder (BD) is a serious mental illness, characterised by the alternating occurrence of manic, hypomanic, depressive, mixed, and euthymic mood episodes (1). In the Netherlands BD has the lifetime prevalence of 1.3% (2). According to Diagnostic Statistical Manual of Mental Disorders fifth edition (DSM-5) two major types of BD exist. Type I is diagnosed in the presence of at least one episode of mania while BD type II is diagnosed in at least one episode of hypomania and depression (1). Criteria for a manic episode are the core symptoms: abnormally elevated, expansive, or irritable mood, combined with at least three of the following symptoms: inflated self-esteem, decreased need for sleep, excessive talking, flight of ideas, distractibility, increased activity, and performing activities that are potentially painful (1) .

The main difference between mania and hypomania is the severity of the manic symptoms. Mania results in severe functional impairment, it may manifest as psychotic symptoms, and often requires hospitalisation on a closed ward (1). Furthermore, BD impacts all aspects of a person's life, causing serious disruption of relationship, employment, and education (1,3). It represents a substantial burden to the patient, their care providers and the society (3).

Evidence-based treatment of BD type I, is described in guidelines, such as the English National Institute for Health and Care Excellence (NICE)(4) and the Dutch Multidisciplinary Guideline BD (5). The aim of treatment is remission of manic symptoms and limitation of the risk of harm to self and others through hospitalisation (5) and, providing pharmacotherapy in combination with intensive supervision (5-7). Key disciplines that provide this evidence-based treatment are psychiatrists and nurses (5).

Furthermore, forced hospitalisation during a severe manic episode is often unavoidable (8,9), due to poor illness perception of these patients (5). Daggenvoorde et al. have noted that there was a lack of evidence based knowledge about nursing care for these patients. In 2015, they investigated nursing interventions in patients who are admitted because of a manic episode (8). Five main nursing interventions were described: limit setting, motivation of taking medication as prescribed, administration of medication, structuring of day-night rhythm and supportive communication (8).

In our clinical practice it appears that hospitalisation due to a manic episode on a closed ward, greatly affects the patient, and can even be traumatising. Literature about these patients' experiences is limited. In 2015, a systematic review was conducted focusing on experiences of patients with acute psychiatric disorders who required hospitalisation in a closed psychiatric ward (10). The authors stated that the description of patients' experiences were mostly negative. According to patients, nurses perform an important role in these experiences (10). For instance, patients felt humiliated by adverse interaction with the staff (11).

Although their research was substantial, it was limited by omitting to notify how many patients with BD were involved in the respective studies and in which mood state these patients were. Hence, there is a shortness of knowledge in literature about the specific experiences of patients who have been hospitalised on a closed ward during a manic episode. Because knowledge is inadequate, nursing care cannot sufficiently be adjusted to these patients' needs. For this reason, more insight into these experiences is required (8,10). The expansion of this knowledge can aid nurses to improve nursing care for patients in a manic mood state.

Objective

The aim of the study is to gain insight into how patients with a bipolar I disorder, who were hospitalised due to an acute manic episode, experienced the nursing care at a closed ward.

Method

Design

A phenomenological research design was performed. This design is particularly suitable to develop a composite description of the essence of the lived experiences of all participants in this population (12).

Population and setting

By means of purposive sampling thirteen participants were recruited and twelve participants consented to participated. Participants were eligible for inclusion if they met the following criteria: 1) diagnosed with bipolar I disorder according to DSM-5; 2) ≥ eighteen years; 3) able to read, speak and understand Dutch; 4) acute hospitalised because of a manic episode in the past year; 5) in euthymic mood state at the time of the interview. Mood state is considered euthymic when the patient estimates his or her mood state between 40 and 60 on a visual analogue scale of 0 to 100 based on the Life Chart Method Self Rating scale (13). When the subjects have been patients of the researcher, they were excluded.

The study was conducted in three psychiatric hospitals in the Netherlands, due to the small number of patients who are admitted for acute mania (14), members of the Dutch association for BD and their informal caregivers [*Vereniging van Manisch Depressieven en Betrokkenen* (VMDB)] were also asked to participate in this study (15).

Procedure

Recruiting participants was performed in two ways. First, clinicians of three psychiatric hospitals were approached. They received a leaflet with the objectives of the study. Next, the clinicians were requested to ask patients if they wanted to participate. Once the patient expressed an interest, an informed consent was signed, providing permission to communicate participants' contact information to the researcher. Subsequently, an information leaflet was sent to the participant, announcing that the researcher would call one week later.

Second, participants were recruited via the website of the VMDB. Patients were invited to participate in the study by posting an invitation on their online forum (15). Those interested could call or mail the researcher. In this contact the researcher explained the objectives and procedures of the study. If approved, the participant received an information leaflet disclosing that the researcher would call one week later.

In this telephone conversation, in both ways of recruiting, the study objectives and procedures were again explained. When the participant consented to partake, an interview appointment

was made on the participant's preferred location; the psychiatric hospital where the participant received treatment or at participant's home.

Data collection

Data was collected by conducting open interviews, guided by a topic list (Appendix 1), and by keeping a logbook, in which the researcher recorded all thoughts and interpretations. After each interview, a reflection on the interview style and atmosphere during the interview was documented in the logbook to increase the credibility (16-18).The topic list was based on literature (3,5,8-11,19) and peer review. Before the start of the interviews, demographic data were collected. The overall question of the interview formulated as follows: 'How have you experienced the nursing care during your stay on the closed ward when you were suffering from mania?' All interviews were audio-recorded and transcribed verbatim by the first author.

Data analysis

The process of analysis and interviewing was an iterative process; this offered the possibility to adjust the topic list when new insights emerged. The analysis started with reading and rereading the transcripts, and logbook to obtain an overview. The further analysis was guided by the Stevick-Colaizzi-Keen method (20)(Table 1), including bracketing according to the Ahern method (21-23).

To increase confirmability (24), two investigators (PG, JL) coded the first three interviews independently. Next, they compared and discussed their codes until consensus was reached. Subsequently, the first researcher completed the process of analysis and describing findings, and discussed this process with the supervisor (PG) until consensus was reached. After ten interviews, data saturation occurred as no new codes emerged from data (25). To confirm saturation, two more interviews were held, which added no new information.

Furthermore, member-check of the interpretations was performed to increase credibility of the findings (24,26,27). To facilitate the analysis process and increase dependability of the findings, software programme NVivo was used (17)

Insert Table 1

Ethical consideration

This study was conducted according to the principles of the World Medical Association Declaration of Helsinki (28), and in accordance with the Regulation of the Medical Research Involving Human Subjects Act (29). Formal approval was not needed from the Dutch Central Committee on Research Involving Human Subjects (http://www.ccmo.nl/en). The Scientific

Research Committees from all participating hospitals granted approval. All participants signed an informed consent form preceding the interview.

Findings

In March and April 2016 twelve open interviews with a duration of 32 to 66 minutes were conducted. Seven participants were female and five male (Table 2). Eight of the interviews were conducted at participants' home and four at a psychiatric hospital. All participants were enrolled by clinicians of the psychiatric hospitals.

The following overarching themes emerged from the data: ward features, involuntary admission, characteristics of nurses, admission and stay, and nursing interventions. To stipulate the data's authenticity, participants' quotations will illustrate these five themes.

Insert Table 2

Ward features.

According to the participants, the presence of nurses in the living room provides a good atmosphere and sense of security. Nurses provide direction to conversations, fairly divide their attention and use humour.

'Nurses' humour makes the situation tenable…'(G)

A number of participants stated that nurses were scarcely in the living room and too frequently in the office, working on their computer. Furthermore, they indicated that the sense of security increased if nurses intervened immediately when a patient escalated. Yet, a single participant experienced the ward as unsafe after an escalation, because the nurse intervened, yet returned the office while the situation was not yet stable.

Information about the ward rules and how they were applied was sufficiently provided, orally and in writing, to the participants.

Involuntary admission.

In total, seven participants, were admitted involuntary. Nurses provided explanations about the content and process of the involuntary admission to participants. Six of these participants stayed in seclusion for a period; this seclusion occurred in a traditional seclusion room or in an Intensive Care Unit (ICU).

One participant indicated that the seclusion happened very unexpectedly;

'I was suddenly thrown on the ground, like I was a big crook…'(A)

This participant revealed that quiet dialogue could have possibly prevented above mentioned situation. Participants who resided in seclusion felt strongly dependent on nurses, as they would not survive without food distribution. As a result, this dependency aided them to surrender to their caregivers when nurses convinced them of the need of seclusion.

'you are very dependent on them, and thus get a form of love for them'(G)

Nonetheless, experiences with communication and supervision during seclusion were divided. Participants who stayed in ICU had contact with a nurse every half hour, which offered them clarity and calmness. In other cases, participants had to contact the nurse via the intercom, which occasionally took a long time before the nurse responded. For this reason participants felt more agitated.
Moreover, one participant was dissatisfied with personal care in seclusion since there was little water to wash hands, toilet paper was hardly available,

'and the smell of the toilet remained in the area; that is inhumane!'(A)

Another participant received toiletries and was very satisfied with personal care during a stay in ICU. Yet, all participants experienced that days lasted long. It was appreciated when nurses jointly ate with participants. Occasionally, a daily schedule was written down,

'Time is enormous, I lived in panic and chaos, and a nurse wrote down: when to smoke, when to eat, which was a relief in time..'(I)

Furthermore, nurses communicated clearly with most participants regarding what kind of behavior was expected of them to end the seclusion.
Finally, the majority of the participants had no clear memories of the period in seclusion, some of them missed the offer for reflecting on this period with nurses who were involved, answering questions might have provided peace of mind.

Characteristics of nurses.

According to participants, nurses at a closed ward are often the first point of contact, yet nurses are not always recognisable, and difficult to distinguish from fellow patients.

"in the beginning there was a young man who told me: we'll never leave here, and that I believed because I did not know he was a patient"(H)

This increased existing confusion. Participants indicated that it would be more clear if they could see who is a nurse by the means of a name tag. Once participants had identified the nurses, they were easy accessible and approachable. According to most participants, nurses listened attentively and have a clear, calm, and trustworthy way of communicating. Additionally, participants mentioned that they became calmer during panic and chaos when the nurses communicated in a quiet way and made clear appointments.

'The calmer they responded, the calmer I became.'(D).

Participants appreciated it when nurses used small talk and tried to connect with participants' inner world and interests. Participants also reported other experiences in which the communication was considered noncommittal. Due to lack of inner structure and control, they would like to receive it from outside.

'I could use more direction, I missed it myself..'(J)

During hospitalisation, the majority of participants felt respectfully treated by nurses, because the disease was taken seriously and participants were approached in an equivalent manner to engage in conversation. Nurses who expressed job satisfaction provided participants a sense of security. Nevertheless, a number of participants noticed a difference in work attitude between novice (in their twenties) and seasoned nurses. For instance, novices adhere strictly to the rules whereas seasoned nurses were more flexible. Participants experienced the latter, personal approach as more comfortable.

Admission and stay.

Some participants remembered they were sufficiently explained, at the start of their hospitalisation, that admission was necessary. One participant explicitly indicated how satisfied she was with the first reception;

'two nurses welcomed me kindly, I was offered coffee, my pet could stay with me, so it provided me a very comforting feeling'(B)

Yet, according to another participant, the nurses hardly paid any attention to the relatives. Furthermore, the other participants had little memory of the first reception at the closed ward.

'Lot of things of the beginning of my hospitalisation, I do not remember…'(C)

Some participants revealed they had received sufficient reflection upon their mental state. These participants appreciated that nurses observed improvement because,

"This is encouraging, when you hear, it is going well with me, then you'd think about going home."(K)

Nevertheless, the majority of the participants felt that they had insufficient reflection upon their mental state. As a result, it was unclear what they had to work towards, for instance, what behaviour was expected to gain more freedom or to be discharged.

'If I had known, I could have made more focused plans…….how I am going to work to discharge.'(M)

One participant could manage stress levels properly, due to involvement in planning the discharge date.
Overall, participants were satisfied that nurses communicated well during change of shifts, and that nurses represented the interest' of participants properly at other disciplines, such as psychiatrists.

Nursing interventions.

a) Medication distribution.

Participants illuminate that medication distribution is a vital task of nurses. As such, nurses apply medication and observe whether the medication was taken. If necessary, they explain the effects of medication on the disease symptoms. However, some participants initially refused to take medication. Consequently, nurses attempted, in various manners, to convince participants that medication intake was necessary.

'They are smart negotiators.'(A)

A reason why some participants refused to take their medicine was that they feared poisoning. Nonetheless, it is unclear whether the nurses were aware of these thoughts.

b) Basic care.

Most participants called the offered day programme limited.

'There was much empty time, time passed slowly…'(F)

Therefore, participants occasionally felt abandoned to their fate, and were often smoking. Nevertheless, participants appreciated it if they could go out for a walk with the nurse, which offered contact with the outside world and a sense of belonging. On some wards, having dinner was a group activity, this provided structure to their day and sense of time. According to a few participants nurses made a written personal day programme, which presented rest and structure and contributed to recovery.

c) Guidance of patients.

Some participants mentioned that limits established by nurses helped them to define themselves in what they were doing and helped to become in touch with reality. Moreover, limits were regarded as protection against, for instance, spending too much money, disruption of contact with relatives or exhaustion.

> *'I knew, they wanted the best for me...'(B)*

Yet, boundaries were often experienced as difficult, yet being well motivated and with humour, made it easier to accept this.

Generally, participants were provided clear explanation about the importance of good sleep. Nonetheless, additional psychoeducation about the disease was not offered.

Anger, for different reasons, is an emotion that regularly occur in a number of participants. When nurses listened to the participants, exhibited interest in the cause of anger and responded calmly, it contributed to anger management.

> *'I was furious, thought my friend had betrayed me, by conversations with a nurse gave me a different view..'(D)*

Discussion

This study explored the experiences of patients, in a manic episode, with nursing care on the closed ward. As such, the following themes are identified: ward features, involuntary admission, characteristics of nurses, admission and stay, and nursing interventions.

According to participants, nurses are often the first point of contact to patients, yet, they are not always recognisable for patients and occasionally mistaken for fellow patients, which can result in harmful situations.

Our findings indicate that communication is an imperative skill for nurses on a closed ward. Nurses use their communication skills in managing escalations and anger of patients. This is congruent with the study of Daggenvoorde et al, nurses describe their communication interventions as one of the most important interventions (8). Our study shows that a calm response has a favourable effect on the patients. This contributes to a safe environment on the ward, in addition to the presence of nurses in the living room. A safe environment contributes to a good ward atmosphere and atmosphere is a key factor in patient satisfaction (30). Communication skills are also used to motivate patients to take their medication, which is also mentioned as a main intervention of nurses (8).

Participants in our study indicate to be well informed about the ward rules and how they are applied, which is in contrast with the review of Van Nugteren et al (10). In addition, the review described that patients report feelings of humiliation, among others, caused by adverse interaction with the staff. In our study, the majority of participants felt respectfully treated by nurses. Furthermore, it should be noted that a number of participants noticed that novice nurses adhere more strictly to the rules whereas seasoned nurses were more flexible. The participants experienced this latter, personal approach more comfortable. The difference in approach between novices and seasoned nurses is probably related to work experience. This is in line with previous research (31,32). For example, Roche et al explored on six mental health units nurses' ability and willingness to engage in a therapeutic relationship and stated that experience is of strong influence on role competence (31). Additionally, Benner has theoretically grounded the development of a skill in five levels of proficiency and stated that novices exhibit more rule-governed behaviour (32).

The majority of the participants in our study received limited information about their performance and treatment goals, as well which behaviour is required to gain more freedom or to discharge. These experiences are in agreement with the findings of the mentioned review (10), nonetheless, in our study, participants expressed no feelings of anger or fear as a result, they mentioned that, if they had known, they could have made more focused plans. In addition, these experiences correspond also to the study of Daggenvoorde et al, because nurses appear to be less accustomed to talk about patient outcomes (8).

A possible explanation for the difference in findings between this study and the mentioned review is that the included studies in the review are conducted in various countries with different types of healthcare systems, patient populations, staffing levels and moreover, these studies were conducted in 2006, and earlier (10). Since 2006, a transition occurred in mental-health care with respect to seclusion in the Netherlands (33). The objective of this transition is reduction of coercion and seclusion. Therefore, seclusion rooms are replaced by ICUs with intensive supervision to prevent traumatisation (33). However, this change has not yet been implemented everywhere in the Netherlands which could explain the salient differences in experiences in our study. In contrast to participants in seclusion rooms, participants in ICUs are satisfied with nursing care, despite their troubled situation.

Strengths and limitations.

Our study is conducted on four wards, attached to three psychiatric hospitals in the Netherlands, which increases the transferability of the findings, as well as the thick description. Additionally, our study is only focused on the experiences of patients with BD, while other studies often focus on patients with a variety of diagnoses (10). Furthermore, strategies to increase the trustworthiness are taken in account; credibility was enhanced by peer-debriefing and member-checking (27). In the member-check no new relevant data emerged. Finally, bracketing was performed during data collection and analysing, this increases confirmability. Limitations should be acknowledged. First, a selection bias might have occurred, as clinicians may have only suggested participants who are quite capable to share their experiences. Second, research reveals that many patients after an acute episode of depression of (hypo)mania withdraw from further treatment (34), while only participants who are motivated for treatment and in contact with clinicians may have participated in this study.

Implications for practice and further research.

The findings of this study underscore the importance that nurses should ensure that patients recognise them by, for instance, using a nametag. Nurses should also ensure they are present as much as possible in the living room to enhance patients' sense of security. As participants' experiences with care into ICUs are more positive than in seclusion rooms, further transformation of traditional seclusion rooms in ICUs is required. In addition, it is recommended that nurses use their communication skills in favour of defining clear treatment goals in consultation with patients. Moreover, when recruiting new nurses, a proper balance between novice and seasoned nurses in the team must be respected. Additionally, it is important that novice nurses receive training in dealing with these vulnerable patients.

Future research should be aimed at gaining consensus which nursing interventions actually contribute to the achievement of desired patient outcomes, for instance through a Delphi technique (35), where patients and nurses are the main experts.

Conclusion

To summarise, nurses are usually the first point of contact and greatly affect experiences of patients with BD who are hospitalised on the closed ward. Furthermore, experiences of nursing care are variable. Central in the positive experiences is that participants felt respectfully approached in addition to the clear and quiet communication which assisted participants to become calmer. In addition, participants' experiences with care in ICUs are more positive than in traditional seclusion rooms. Recognisability of nurses on the closed ward also leaves room for improvement. Finally, it is recommended to define clear treatment goals in consultation with patients.

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Table 1

Six steps of Stevick-Colaizzi-Keen analysis method

Step 1	The researcher described the experiences with the phenomenon under study according to the Ahern method (21-23). This implies that the author described and discussed her own experiences in the research group as part of bracketing. This is an attempt to set aside the researcher's personal experiences with the phenomenon.
Step 2	The researcher developed a list of significant statements from the text of the verbatim transcripts of the interviews about how participants experience the nursing care during their hospitalisation, and developed a list of non-repetitive, non-overlapping statements.
Step 3	The researcher took the significant statements and grouped them into larger units of information; meaning units or themes.
Step 4	The researcher wrote a description of what the participants in this study experienced with the phenomenon; the textural description.
Step 5	The researcher wrote a description of how the experience happened; structural description. The researcher also reflected on the setting and context in which the phenomenon was experienced.
Step 6	The researcher wrote the essence of the experience of the hospitalized patients in a manic episode by incorporating the textural and structural descriptions

Table 2

Characteristics of participants

Participant	Gender	Age (years)	Duration admission (days)	Unvoluntary admission	Seclusion
A	Woman	50	23	+	+
B	Woman	45	28	-	-
C	Man	53	31	+	+
D	Man	41	91	+	+
E	Woman	53	21	+	+
F	Woman	52	35	+	+
G	Woman	26	61	+	-
H	Woman	54	18	-	-
I	Man	43	61	-	+
J	Man	45	25	+	-
K	Woman	44	18	-	-
L	-				
M	Man	33	14	-	-

Note. +=yes -=no

Appendix 1

Topic list for interviews

Structured questions:

1. When were you admitted to the hospital?
2. How long have you been admitted to the hospital?
3. Was it a voluntary or involuntary hospitalisation?
4. Have you been hospitalized before for a manic episode?
5. How many times?
6. What is your age?

Overall question:

How have you experienced the nursing care during hospitalisation for manic episode?

- Topics:
  - ✓ Information
  - ✓ Communication
  - ✓ Time for interaction
  - ✓ Humiliation
  - ✓ Limit setting
  - ✓ Motivation for taking medication
  - ✓ Structuring day-night rhythm
  - ✓ Contact informal caregivers

Last questions: Is there anything else you would like to tell me? Or: Are there any other questions that you think that I should asked you?

Samenvatting

Achtergrond

Bipolaire stoornis is een ernstige psychiatrische ziekte met een recidiverende beloop. Depressieve, hypomane en manische episoden, worden afgewisseld met symptoomvrije intervallen. Een ziekenhuisopname op een gesloten afdeling is vaak onontkoombaar bij een ernstige manische ontregeling vanwege het risico op schade voor zichzelf en anderen. Tijdens deze opname is farmacotherapie in combinatie met intensieve verpleging essentieel. Literatuur over de ervaringen van patiënten met de verpleegkundige zorg is beperkt. Mogelijk sluit daardoor de verpleegkundige zorg onvoldoende aan bij de zorgbehoeften van desbetreffende patiënten. Toevoeging van deze kennis kan verpleegkundigen helpen de zorg beter af te stemmen op de zorgbehoeften van de patiënt.

Doel

Het doel van deze studie is inzicht verkrijgen in hoe patiënten, gediagnosticeerd met bipolaire I stoornis en opgenomen op een gesloten afdeling tijdens een manische episode, de verpleegkundige zorg hebben ervaren.

Methode

De studie heeft een fenomenologisch design. Participanten zijn op doelgerichte wijze gerekruteerd in drie instellingen in Nederland. Twaalf participanten zijn geïnterviewd, zij zijn het afgelopen jaar opgenomen geweest op een gesloten afdeling in verband met een manische episode. Data analyse is uitgevoerd volgens de Stevick-Colaizzi-Keen methode.

Resultaten

De vijf volgende thema's zijn geïdentificeerd: afdelingskenmerken, kenmerken van verpleegkundigen, opname proces, onvrijwillige opname en verpleegkundige interventies.

Conclusie

Verpleegkundigen zijn op de afdeling het eerste aanspreekpunt, maar zijn vaak niet herkenbaar voor patiënten. Duidelijke en rustige wijze van communiceren draagt er aan bij dat patiënten rustiger worden. Daarnaast blijkt dat behandeldoelen onvoldoende worden gecommuniceerd met patiënten waardoor patiënten niet goed weten waar zij aan toe zijn. Patiënten ervaringen met de Intensive Care Unit zijn positiever dan met de traditionele separeer.

Aanbevelingen

Het is belangrijk dat verpleegkundigen zich er van vergewissen dat zij herkenbaar zijn voor patiënten. Daarnaast is het van belang dat er met de patiënt gezamenlijke behandeldoelen worden opgesteld.

Sleutelwoorden: Bipolaire stoornis, gesloten afdeling, verpleging, patiënten ervaringen