The incidence and nature of positive experiences in acute psychiatry: An exploratory study

Student	W.A. Nugteren
Student number	3850293
Status of paper	Final version
Date	21 August 2014
Institute	Utrecht university, University Medical Centre Utrecht masteropleiding Klinische Gezondheidswetenschappen, masterprogramma Verplegingswetenschap
Master course	Clinical Health Sciences
Master program	Nursing Science
Supervisors	Prof Dr. B. van Meijel and Drs. C.G.J.M van der Venne
Course lecturer	Dr. I.E. Poslawsky
Internship institution	Parnassia Psychiatric Institute, The Hague
Targeted journal	International journal of mental health care; max 4000 words in 6th APA
Reference style	AMA American Medical Association 10th edition
Number of words	3219
Guideline for transparent reporting	STROBE statement
Number of words Dutch summary	299
Number of words English abstract	286

Background

Mental illnesses can be the cause of all sorts of disruptive behaviours - like aggression, suicidal and self-harming behaviour - that result in safety issues for both patients and their surroundings[1,2]. In these cases voluntary or involuntary admission to a psychiatric unit might be necessary for protection of the patient and/or people in his environment[3]. The total rates for both voluntary and involuntary admission to clinical settings differ considerably between European countries, with a median of 568 per 100,000 residents[4]. In The Netherlands, with 17 million inhabitants, the number of involuntary admissions was 80 per 100,000 residents in 2009[5]. These numbers implicate that the group of patients receiving inpatient psychiatric care, whether or not by forced admission, is extensive.

Often admission to inpatient psychiatric care is not enough to prevent disruptive behaviour[6]. In case of severe disruptive behaviour on the ward, coercive measures may be necessary to cope with the crisis[7]. The most prevalent forms of coercion in Europe are forced medication, restraint and seclusion[8]. Generally, the use of coercive measures evokes negative feelings in patients[9,10], including feelings of anxiety and fear, humiliation and serious distress[11,12]. Also, more common events during admission can be the source of negative experiences, like unsatisfactory communication with nursing staff, witnessing other patients undergoing coercive measures, and the deprivation of liberty[12,13]. Often these negative experiences are related to so-called sanctuary harm[11], referring to insensitive, inappropriate, neglectful, or abusive actions by staff or associated authority figures, that evoke in customers a response of fear, helplessness, distress, humiliation, or loss of trust in psychiatric staff. These actions are in conflict with the obvious importance of good contact between patient and nursing staff and are probably associated with less favourable subjective evaluations and treatment outcomes of patients[14].

In recent years there is a growing attention for iatrogenic harm and related negative experiences of psychiatric patients, caused by hospital stay and coercive events occurring on the ward[12,15,16]. These studies focus mainly on the negative experiences of hospital stay. Research on what patients describe as positive and helpful during their hospital stay is scarce. In small qualitative research on patients' experiences on acute psychiatric wards, contact with family, constructive support from nursing staff and sufficient explanation about the reasons and duration of coercive measures was described as positive and helpful[15-17]. Unfortunately, these findings were mainly based on small qualitative research, and data were not systematically acquired in large patient groups.

Problem statement

Research on patients' experiences on acute psychiatric wards mainly focuses on negative experiences. As a consequence, there is insufficient knowledge about positive and helpful experiences during hospital stay and coercive measures. Coercive measures cannot be totally avoided during hospital stay. Therefor, research on perceived positive experiences in relation to voluntary and involuntary psychiatric hospital stay and undergoing coercive measures is needed.

Aim

The aim of this research is to gain insight in what patients describe as positive experiences concerning their hospital stay and the undergone coercive measures. The results of this research can be used to make nursing staff more aware of these positive experiences expressed by psychiatric patients. These insights can be used to optimal assist patients during the burdensome period of the hospital stay and to minimize or even prevent traumatic experiences.

Research Questions

- What is the incidence of positive experiences in patients admitted to an acute psychiatric ward?
- What is the nature of these positive experiences?
- What is the importance of positive experiences in patients who underwent coercive measures?

Methods

Design

We used an exploratory design to investigate the dimensions of patients' positive experiences on an acute psychiatric ward[18] and conducted an exploratory, cross-sectional study. We collected data in two psychiatric institutions using semi-structured interviews. This research was part of a larger descriptive study investigating the relationship between undergoing coercive measures and the development of posttraumatic stress disorder (PTSD) symptoms.

Setting and Subjects

Between February 2014 and August 2014 we recruited all eligible adult patients from five closed, acute wards of two general psychiatric hospitals in the western part of the Netherlands. The wards have 88 beds, annually admit nearly 2100 patients and have a catchment area of approximately 1,6 million inhabitants. Patients were eligible when they were able to communicate in Dutch and experienced one or more of the following three coercive measures: stay on a closed ward with any form of freedom restrictions to leave the ward, forced medication (both oral and intramuscular), and seclusion with or without forced medication. The research was conducted in accordance with the ethical guidelines contained in the declaration of Helsinki and approved by the Dutch Regional Medical Ethics Committee (No. NL39420.058.13).

Procedure

An independent researcher approached the patients when all freedom restrictions were withdrawn, as this is a sign of improvement of psychiatric disease. This researcher provided oral and written information about the study and obtained written informed consent for the interview. When more eligible patients were present on the ward than could be interviewed that day, we randomly selected patients for interviewing by using the room numbers of the patients. On the first day we started top to bottom and vice versa the next day. Patients received a fee of € 10.00 after completing the interview.

Data collection

We collected the following baseline characteristics from the electronic patient file: age, gender, legal status, ethnicity, DSM IV diagnosis, severity of psychopathology types of coercive measures (closed ward, forced medication and seclusion (whether or not in combination with forced medication)), and coercive measures experienced during previous admissions.

The present research is a sub-study of a larger research project, focusing on the association between undergoing coercive measures and the possible development of PTSD symptoms. In this larger study multiple questionnaires are combined in a comprehensive interview. The total interview consists of four questionnaires: i.e. (1) The Patient Experience Questionnaire (PEQ), an instrument to assess a wide range of traumatic and harmful experiences that may occur within psychiatric settings[12,19]; (2) The Life Events Checklist (LEC), a questionnaire to screen for lifetime exposure to potential traumatizing events[20]; (3) The Coercion Experience Scale (CES), a questionnaire to assess restrictions of human rights from the patient's point of view and several stressors experienced during coercive measures[16], and (4) The Dutch Brief Coping Indicator Scale (DuBriCSI), a questionnaire to assess the patients' coping strategies[21].

Questions on positive events

The four questionnaires are supplemented with a number of self-formulated questions, aiming to investigate the patients' subjective positive experiences. These questions provide the core data for the present research. At the present moment no validated instrument is available for the measurement of positive experiences in this patient group. We started this part of the interview with the following question: "*So far, we have asked questions about events that may have been stressful for you. However, we would also like to know if you had any positive experiences during this hospital stay".* When patients answered positively, this was followed by the questions: *"Could you please specify these positive experiences?'* and *"Can you explain why this was a positive event for you?"* The purpose of the open-ended question was to obtain a first spontaneous reaction from the patients. Following these open-ended questions, we inquired about a number of predefined positive experiences in relation to undergoing coercive measures, as extracted from the literature[11,15,22-25]. These events were described in literature as supporting during undergoing coercive measures. We used these events as prompts for the patients during the interview to consider some aspects that did not come into their minds initially. Therefore we included them after the open-ended questions. The structured, closed questions on positive experiences were:

- *Did you, during the coercive measure, have contact with family, friends or other loved ones?*
- *Did you, during the coercive measure, have contact with staff when you wanted?*
- *Did you, during the coercive measure, have personal belongings near you or visible for you?*
- *When you underwent the coercive measure, was the reason clear to you?*
- *Did you, during the coercive measure, know how long the coercive measure would be expected to last?*

When patients answered positively on these closed questions, we proceeded with the following question: "*Did this alleviate the burden of the coercive measure?"* When this second question was answered positively, this was followed by the final question: *"How important was this for you, on a scale 0-10, 0=not important, 10=maximum importance?"* To ensure we would not miss important elements related to coercive measures, we discussed the content and structure of our semi-structured interview with three lay experts, familiar with coercive measures. Lay experts are former patients, who received training to work as staff member on the ward. They had no additions to our questions.

Data analyses

We analysed baseline characteristics of the participating patients descriptively as mean values with standard deviation. DSM IV diagnoses were categorized in psychosis, mood disorder, personality disorder and 'other'. Ethnicity was defined as western or non-western. We analysed the incidence of the positive experiences during hospital stay descriptively and reported the results as frequencies. We used the method of content analyses to describe the nature of the positive experiences. Content analysis is an appropriate method to quantify qualitative data[26]. The statements received from the open-ended questions were coded. Key phrases difficult to code were discussed in the research group until agreement was reached. We counted the frequency of each coded positive experience. We reported the incidences of the predefined positive experiences during coercive measures and the scores on the question whether or not it led to alleviation as frequencies. We reported the subjective importance as a mean score with its standard deviation and range. We used a chi-square test to test for differences between the two forms of coercive measures (seclusion and closed ward) and number of reported positive events. We used IBM SPSS Statistics version 22.

Results

Attrition analyses

During the study period, 146 patients were eligible and 103 patients were randomly selected to participate in this study. However, 26 patients were not present at the ward and could not be approached. We approached 77 patients of which 29 refused to cooperate with the interview. We included the remaining 48 patients. Seven patients did not complete the full interview. Five patients wanted to stop because of the burden induced by unpleasant memories and for two non-Dutch speakers the questions were too difficult to understand. We found no significant differences in gender and age between participants and those who refused to participate. However, diagnosis and legal status differed significantly; patients who

refused to cooperate were more often involuntarily admitted (p=0.039) and suffered more often from psychotic disorders (p=0.001).

Baseline characteristics

Baseline characteristics of the participants are presented in Table 1. Patients were on average 37,7 years old (*SD*=13.0), and 50% of the patients were male. Psychosis (57%) was the most prevalent diagnosis and 23 (51%) patients were involuntary admitted.

[Table 1 around here]

Positive experiences

Positive experiences during hospital stay

Forty-three patients answered the open-ended question: “Did you have any positive experiences during your stay on the ward”. Forty patients (93%) answered positive. Thirty-nine patients described the nature of the positive experiences they had during their hospital stay. Twenty-seven patients mentioned contact with nursing staff as a positive experience during hospital stay. According to the patients, the nursing staff was helpful and friendly. They took the time to make contact with the patients, to talk, and listen to them. Furthermore, nurses helped to cope with the consequences of psychiatric crisis and to endure difficult times on the ward. Fourteen patients mentioned the daily activities provided on the ward as a positive experience. Patients especially preferred the provided sports activities and the possibility to walk on the hospital compound. They liked the availability of supervised leisure activities, where they could use the computer, play pool and paint. Contact with fellow patients was a positive aspect of hospital stay for ten of the participating patients. They liked the familiarity and the possibility to exchange experiences with other patients. Five patients described contact with family as a positive experience. Contact with family was appreciated because of their support during difficult times of hospital stay.

Predefined positive events during coercive measures

Thirty-three patients responded to the questions on predefined positive events during coercive measures. The results are displayed in table 2 and 3. Twenty-four patients (73%) described they could have contact with staff when they wanted. Twenty patients (61%) had contact with their family during the coercive measure. For 23 patients (70%) the reason for the use of the coercive measure was clear. These percentages were significantly lower for secluded patients compared to non-secluded patients on the ward (table 3). Eight secluded patients (40%) reported contact with family, compared to the closed ward group, where all patients had contact with family (p=0.001). Furthermore, 12 secluded patients (60%) knew the reason of the measure, compared to the closed ward group where all patients knew the reason for the measure (p=0.028).

During the coercive measure around three-quarter of the patients felt that contact with family, contact with staff when wanted and the vicinity of personal belongings, alleviated the burden of the measure. Knowledge of the reason and duration of the measure was felt as alleviation by 60% of the patients (table 2). Knowledge of the reason for applying the coercive measure was valued with a 8.8 (SD=1.0), contact with family during the coercive measure with a 8.6 (SD=1.4). Contact with nursing staff, when patients wanted, was valued with a 7.6 (SD=1.9) (table 2).

[Table 2 around here]

[Table 3 around here]

Discussion

This research shows that positive experiences are more common during stay on a psychiatric ward then we expected based on the literature, even after involuntary admission. Supportive contact with nurses was, among other things, helpful and cooperative and thereby the most prevalent positive experience. During coercive measures, patients valued contact with family and understanding of the reason for the coercive measure the most.
In previous research on acute psychiatric wards, patients frequently described interactions with nursing staff in a negative way. In qualitative research, over 60% of the patients described contact with staff as negative or very negative[27], thereby unintentionally causing psychological damage, resulting in sanctuary harm[11]. Patients reported feeling alienated while nursing staff was too busy to engage in meaningful interactions[25] and to achieve the closeness that would be beneficial for the patient[17]. This is in contradiction with our findings, where nearly two-third of patients described contact with staff as one of the most important positive experience during hospital stay. Patients expressed feelings of being heard and they appreciated the positive relationship and cooperation with nursing staff. Our findings are supported by previous findings that interpersonal contact with nursing staff is helpful, important and a positive part of hospital stay[16,23]. These conflicting findings can arise from differences in patient-staff rates, usage of coercion types or execution of coercive measures in the country of origin[8]. Since 2006, the Dutch government policy concerning mental health care included reducing the use of coercive measures, therefor financing interaction training and educational programs, including hospitality training[28]. For that reason, the nurses on the researched wards may have paid extra attention to the patient demands in terms of patient-staff collaboration and hospitality.
Contact with family and close relatives is an important requirement for patients to feel safe during the first days of hospital stay[15,23]. The presence of familiar people brings security,

support and the certainty for the patient that somebody cares for him. Furthermore, partners and family can have a significant positive impact on a patients' attitude to involuntary hospitalization and receiving compulsory treatment, convincing patients that treatment is necessary[27]. These findings correspond with our findings, where patients evaluated contact with family and relatives with an average score of 8.6 on a 10-point scale. Remarkable is that nearly 40% of our patients reported they did not have contact with family or relatives during their seclusion period. We found no other studies to compare these findings with. This is probably because the importance and involvement of family in the acute psychiatric setting is under-exposed and under-appreciated[29]. Involvement of family usually depends on preferences and actions of individual nurses, instead of hospital policy[29].

Admitted patients on acute wards express a lack of information in general and a lack of information concerning the coercive measures in particular[13]. For example, patients express feelings of anxiety and anger because length of stay is unclear[24]. Furthermore, patients find the reasons for coercive measures unclear and consider the discussion concerning possible alternatives for coercion insufficient[15,23]. These findings correspond with our findings that three-quarter of patients reported having no knowledge of their length of stay or duration of the coercive measure. Furthermore, only half of the secluded patients understood the reason for the use of the seclusion. Knowledge about the reason and duration of the coercive measure was however valued with a 8.8 and 8.0 respectively. Uncertainty about the duration of the admission or seclusion is difficult to avoid and can arises from different factors. These include the individual and unpredictable recovery process of mental illnesses and the difficulty nurses have to provide meaningful information[13].

This study has several strengths. The researchers, without interference or mediation of nursing staff, approached all patients who met the inclusion criteria, resulting in an unselected and representative sample of the ward population. This is in contrast with most qualitative interviews, in which psychotic patients are generally underrepresented[17,30,31]. Furthermore, patients were still admitted when interviewed, leading to a relatively short time between the event and interview. This reduces the chance of recall bias.

Our study also has some limitations. First, we were not able to use a validated instrument, so we used a self-developed instrument for the interview. However, this instrument was based on relevant literature and was validated by lay experts. This method compromises the internal validity. A second limitation concerns the generalizability. The patients were recruited from only two mental health institutions. The use of seclusion differs significantly between Dutch wards[32]. Also, patients with forced medication on the ward were underrepresented. Moreover, there was a significant difference between participants and those who refused to participate. Involuntary admitted and psychotic patients significantly more often refused to cooperate in this research.

Conclusion

Ninety-three percent of the patients on an acute psychiatric ward described one or more positive experiences. The nature of these positive experiences exists mainly of contact with nursing staff and daily activities on the ward. The most important events during coercive measures were contact with family and knowledge about the reason of the coercive measure.

Recommendations

Psychiatric nurses play an important role in patients' recovery process during hospital stay. Patients refer to them as a positive experience of their hospital stay. Staff, management and policy makers may not be aware and may not appreciate this. Therefore, it is important to spread this information into the nursing community and create awareness of this important role under nurses themselves, staff, management and policy makers. We also recommend inviting the patients' family during coercive treatment, especially during seclusion. This happens apparently not quite often, yet it is highly appreciated by patients and easy to implement. For future research, we recommend to extent and validate a questionnaire on positive experiences, during both hospital stay and specific coercive measures. Afterwards we recommend to extent this research to a bigger sample and finally to investigate the extent in which positive experience can prevent the possible onset of trauma on psychiatric wards.

References

1. Naudts K, Hodgins S. Neurobiological correlates of violent behavior among persons with schizophrenia. *Schizophr Bull*. 2006;32(3):562-572. Accessed 21 August 2014.

2. Arseneault L, Moffitt TE, Caspi A, Taylor PJ, Silva PA. Mental disorders and violence in a total birth cohort: Results from the dunedin study. *Arch Gen Psychiatry*. 2000;57(10):979-986. Accessed 21 August 2014.

3. Mericle AA, Havassy BE. Characteristics of recent violence among entrants to acute mental health and substance abuse services. *Soc Psychiatry Psychiatr Epidemiol*. 2008;43(5):392-402. Accessed 21 August 2014.

4. WHO World Mental Health Survey Consortium. Facts and figures: Prevalence of mental disorders. http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/mental-health/facts-and-figures. Updated 2014. Accessed 08/16, 2014.

5. Schoevaerts K, Bruffaerts R, Mulder CL, Vandenberghe J. An increase of compulsory admissions in belgium and the netherlands: An epidemiological exploration. *Tijdschrift voor Psychiatrie*. 2013;55(1):45-55. Accessed 27 July 2014.

6. Foster C, Bowers L, Nijman H. Aggressive behaviour on acute psychiatric wards: Prevalence, severity and management. *J Adv Nurs*. 2007;58(2):140-149. Accessed 21 August 2014.

7. Cornaggia CM, Beghi M, Pavone F, Barale F. Aggression in psychiatry wards: A systematic review. *Psychiatry Res*. 2011;189(1):10-20. Accessed 25 July 2014.

8. Raboch J, Kališová L, Nawka A, et al. Use of coercive measures during involuntary hospitalization: Findings from ten european countries. *Psychiatric Services*. 2010;61(10):1012-1017. Accessed 27 July 2014.

9. Bergk J, Einsiedler B, Flammer E, Steinert T. A randomized controlled comparison of seclusion and mechanical restraint in inpatient settings. *Psychiatr Serv*. 2011;62(11):1310-1317. doi: 10.1176/appi.ps.62.11.1310; 10.1176/appi.ps.62.11.1310.

10. Georgieva I, Mulder CL, Whittington R. Evaluation of behavioral changes and subjective distress after exposure to coercive inpatient interventions. *BMC Psychiatry*. 2012;12:54-244X-12-54. doi: 10.1186/1471-244X-12-54; 10.1186/1471-244X-12-54.

11. Robins CS, Sauvageot JA, Cusack KJ, Suffoletta-Maierle S, Frueh BC. Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. *Psychiatric Services*. 2005;56(9):1134-1138. Accessed 20051011. doi: http://dx.doi.org/10.1176/appi.ps.56.9.1134.

12. Frueh BC, Knapp RG, Cusack KJ, et al. Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatr Serv*. 2005;56(9):1123-1133. doi: 10.1176/appi.ps.56.9.1123.

13. Nugteren W, van der Zalm Y, Hafsteinsdóttir T, van der Venne C, Kool N, van Meijel B. Experiences of patients on acute and closed psychiatric wards. A systematic review. *perspectives in psychiatric care*. submitted 2014.

14. Wallsten T, Kjellin L, Lindström L. Short-term outcome of inpatient psychiatric care - impact of coercion and treatment characteristics. *Soc Psychiatry Psychiatr Epidemiol*. 2006;41(12):975-980. Accessed 25 July 2014.

15. Johansson IM, Lundman B. Patients' experience of involuntary psychiatric care: Good opportunities and great losses. *J Psychiatr Ment Health Nurs*. 2002;9(6):639-647. Accessed 20021210.

16. Steinert T, Birk M, Flammer E, Bergk J. Subjective distress after seclusion or mechanical restraint: One-year follow-up of a randomized controlled study. *Psychiatr Serv*. 2013;64(10):1012-1017. doi: 10.1176/appi.ps.201200315; 10.1176/appi.ps.201200315.

17. Shattell MM, Andes M, Thomas SP. How patients and nurses experience the acute care psychiatric environment. *Nurs Inq*. 2008;15(3):242-250. Accessed 20080912. doi: http://dx.doi.org/10.1111/j.1440-1800.2008.00397.x.

18. Polit DF, Beck CT. Exploratory and descriptive research. In: Surrena H, Jordan A, eds. *Nursing research.* Ninth edition ed. Wolters Kluwer Health | Lippincott Williams & Wilkins; 2012:640.

19. Cusack KJ, Frueh BC, Hiers T, Suffoletta-Maierle S, Bennett S. Trauma within the psychiatric setting: A preliminary empirical report. *Adm Policy Ment Health*. 2003;30(5):453-460. Accessed 11 August 2014.

20. Gray MJ, Litz BT, Hsu JL, Lombardo TW. Psychometric properties of the life events checklist. *Assessment*. 2004;11(4):330-341. Accessed 11 August 2014.

21. Amirkhan JH. A factor analytically derived measure of coping: The coping strategy indicator. *J Pers Soc Psychol*. 1990;59(5):1066-1074. Accessed 12 August 2014.

22. Thibeault CA, Trudeau K, d'Entremont M, Brown T. Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. *Arch Psychiatr Nurs*. 2010;24(4):216-226. Accessed 20100723. doi: http://dx.doi.org/10.1016/j.apnu.2009.07.002.

23. Koivisto K, Janhonen S, Vaisanen L. Patients' experiences of being helped in an inpatient setting. *J Psychiatr Ment Health Nurs*. 2004;11(3):268-275. doi: http://dx.doi.org/10.1111/j.1365-2850.2003.00705.x.

24. Alexander J. Patients' feelings about ward nursing regimes and involvement in rule construction. *J Psychiatr Ment Health Nurs*. 2006;13(5):543-553. Accessed 20061110. doi: http://dx.doi.org/10.1111/j.1365-2850.2006.00977.x.

25. Stenhouse RC. 'They all said you could come and speak to us': Patients' expectations and experiences of help on an acute psychiatric inpatient ward. *J Psychiatr Ment Health Nurs*. 2011;18(1):74-80. Accessed 20110110. doi: http://dx.doi.org/10.1111/j.1365-2850.2010.01645.x.

26. Hsieh H-, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277-1288. Accessed 2 June 2014.

27. Hughes R, Hayward M, Finlay WML. Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*. 2009;18(2):152-160. Accessed 20091204. doi: http://dx.doi.org/10.1080/09638230802053326.

28. Vruwink FJ, Mulder CL, Noorthoorn EO, Uitenbroek D, Nijman HL. The effects of a nationwide program to reduce seclusion in the netherlands. *BMC Psychiatry*. 2012;12:231-244X-12-231. doi: 10.1186/1471-244X-12-231; 10.1186/1471-244X-12-231.

29. Blomqvist M, Ziegert K. 'Family in the waiting room': A swedish study of nurses' conceptions of family participation in acute psychiatric inpatient settings. *International Journal of Mental Health Nursing*. 2011;20(3):185-194. Accessed 18 August 2014.

30. Kuosmanen L, Hatonen H, Malkavaara H, Kylma J, Valimaki M. Deprivation of liberty in psychiatric hospital care: The patient's perspective. *Nurs Ethics*. 2007;14(5):597-607. Accessed 20070928.

31. Svindseth MF, Dahl AA, Hatling T. Patients' experience of humiliation in the admission process to acute psychiatric wards. *Nord J Psychiatry*. 2007;61(1):47-53. Accessed 20070316.

32. Janssen W, Noorthoorn E, van de Sande R, et al. Zes jaar argus. Vrijheidsbeperkende interventies in de GGz in 2012 en ontwikkelingen ten opzichte van voorgaande jaren. Mei 2014. http://www.ggznederland.nl/uploads/assets/Rapport%20-%20zes%20jaar%20argus%2017062014.pdf.pdf

Tables

Table 1 Baseline characteristic

	All patients
Age in years (SD) n=48	37.4 (12.4)
Gender n=48	
Male (%)	25 (52)
Female (%)	23 (48)
Ethnicity n=46	
Western (%)	27 (59)
Non-Western (%)	19 (41)
Legal status n=45	
Involuntary (%)	23 (51)
Voluntary (%)	22 (49)
DSM IV diagnosis n= 47	
Psychosis (%)	25 (53)
Mood disorder (%)	18 (38)
Personality disorder (%)	4 (9)
Previous experience of coercion n=27	
Seclusion and medication n= 27 (%)	Yes= 11 (41)
Only medication n= 27 (%)	Yes= 7 (26)
Closed ward n=26 (%)	Yes= 24 (92)

Table 2 Incidence, alleviation and importance of positive events during coercive measures

Question			Did it alleviate the burden?		What was the importance*?		
	N=	Yes (%)	N=	Yes (%)	N=	Mean (SD)	Range
Did you, during the coercive measure, have contact with family, friends or other loved ones?	33	20 (61)	20	15 (75)	15	8.6 (1.4)	1-10
Did you, during the coercive measure, have contact with staff when you wanted?	33	24 (73)	22	18 (82)	17	7.6 (1.9)	1-10
Did you, during the coercive measure, have personal belongings near you or visible for you?	33	20 (61)	18	14 (78)	14	8.3 (1.4)	5-10
When you underwent the coercive measure, was the reason clear to you?	33	23 (70)	21	13 (62)	12	8.8 (1.0)	5-10
Did you, during the coercive measure, know how long the coercive measure would be expected to last?	32	5 (16)	5	3 (60)	3	8.0 (2.0)	6-10

* Measured on scale 0=not important to 10= extreme important

Table 3 Differences between the two forms of coercive measures (seclusion and closed ward) and number of reported positive events, measured with chi-square test

Event		Seclusion (with or without medication)	Closed ward	Fishers exact test (2-sided)
Did you, during the coercive measure, have contact with family, friends or other loved ones?	Yes	8	11	p=0.001
	No	12	0	
Did you, during the coercive measure, have contact with staff when you wanted?	Yes	12	11	p=0.028
	No	8	0	
Did you, during the coercive measure, have personal belongings near you or visible for you?	Yes	9	10	p=0.020
	No	11	1	
When you underwent the coercive measure, was the reason clear to you?	Yes	12	11	p=0.028
	No	8	0	
Did you, during the coercive measure, know how long the coercive measure would be expected to last?	Yes	4	1	p=0.626
	No	15	10	

Abstract

Background

In recent years there is growing attention for negative experiences of psychiatric patients, caused by hospital stay and coercive events occurring on acute psychiatric wards. Coercive measures cannot be totally avoided and research on positive experiences in relation to psychiatric hospital stay and undergoing coercive measures is therefore needed.

Aim and research question

The aim of this research is to gain insight in what patients describe as positive experiences concerning their hospital stay and the undergone coercive measures. We aim to describe the incidence, nature and importance of positive experiences in patients admitted to an acute psychiatric ward.

Methods

We conducted an exploratory, cross-sectional study using semi-structured interviews. We used self-formulated questions, aiming to investigate the patients' subjective positive experiences. We used the method of content analyses to describe the nature of the positive experiences.

Results

Forty patients (93%) described one or more positive experiences during hospital stay. According to 27 patients (70%) these positive experiences consist of the supporting and helpful contact with nursing staff. During coercive measures, contact with family and knowledge of the reason of the coercive measure, were valued the highest.

Conclusion

Nurses play a positive role during hospitalisation, as 70% of the patients spontaneous referred to them and their actions as positive experiences. During coercive measures, patients would like to have contact with their family and to have knowledge about the reason for using the coercive measure.

Recommendations

We recommend to make nurses more aware of their important role and to invite the patients' family during coercive treatment, especially during seclusion. For further research we recommend to investigate the extent in which positive experiences can prevent the possible onset of trauma on psychiatric wards.

Keywords: Positive effects, Acute psychiatry, Nurses

Samenvatting

Inleiding

Afgelopen jaren is meer aandacht ontstaan voor negatieve ervaringen van psychiatrische patiënten, veroorzaakt door de opname en het gebruik van dwangmaatregelen binnen acute psychiatrische opname afdelingen. Dwangmaatregelen kunnen niet volledig worden vermeden en daarom is onderzoek naar positieve ervaringen in relatie tot het verblijf op de opnameafdeling en het ondergaan van dwangmaatregelen nodig.

Doel en onderzoeksvraag

Het doel van dit onderzoek is om inzicht te krijgen in de positieve ervaringen die patiënten beschrijven in relatie tot hun opname en de gebruikte dwangmaatregelen. We beschrijven de incidentie, aard en het belang van positieve ervaringen bij patiënten opgenomen op acute psychiatrische afdelingen.

Methoden

We hebben een exploratief, cross-sectioneel onderzoek gedaan met behulp van semigestructureerde interviews. Hierbij hebben we gebruik gemaakt van zelf ontworpen vragenlijsten, bedoeld om de subjectieve ervaringen van patiënten te onderzoeken. We hebben content analyses gebruikt om de aard van de positieve ervaringen te beschrijven.

Resultaten

Veertig patiënten (93%) beschreven één of meer positieve ervaringen tijdens hun opname. Volgens 27 patiënten (70%) bestonden deze ervaringen uit ondersteunende en behulpzame ervaringen met verpleegkundigen. Tijdens de dwangmaatregelen vinden patiënten contact met familie en kennis over de reden van de toegepaste dwang het belangrijkst.

Conclusie

Verpleegkundigen spelen een belangrijke rol tijdens de opname op een acute psychiatrische afdeling: 70% van de patiënten refereert spontaan aan de verpleegkundigen en hun handelingen als positieve ervaring. Tijdens dwangmaatregelen hebben patiënten graag contact met hun familie en kennis over de reden van de dwangmaatregel.

Aanbevelingen

We raden aan om verpleegkundigen zich meer bewust te maken van de belangrijke rol die zij hebben en om familie van patiënten uit te nodigen tijdens dwangtoepassingen, met name separatie. Voor vervolgonderzoek raden we aan om te onderzoeken of positieve ervaringen mogelijk een preventieve werkingen hebben bij het ontstaan van trauma op psychiatrische afdelingen.

Trefwoorden: Positieve ervaringen, Acute psychiatrie, Verpleegkundigen.