

“When in Rome”

A Grounded Theory Analysis of Service Users’ Experiences of Ward Rounds.

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BSc (Hons) MSc**

A thesis submitted in partial fulfilment
of the requirements of the
Doctorate in Clinical Psychology

**University of Leicester
June 2007**

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DECLARATION

This Thesis, submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology, is based upon work conducted by the author in the Department of Clinical Psychology at the University of Leicester between September 2005 and July 2007. All work recorded in this Thesis is original unless otherwise acknowledged in the text by reference. None of the work has been submitted for another degree in this or any other University.

Word Count

	<i>Without References</i>	<i>With References</i>
<i>Thesis Abstract</i>	297	297
<i>Literature Review</i>	6331	6784
<i>Research Report</i>	12759	13594
<i>Critical Appraisal</i>	4929	5174
<i>SUB TOTAL</i>	24316	25849
<i>Appendices</i>	5000	5000
<i>TOTAL</i>	29316	30849

THESIS ABSTRACT

Ward rounds are a fundamental part and regular feature of a service user's care in most inpatient settings. The general purpose of the ward round is to review care, plan treatment, evaluate progress, plan for discharge and provide information for carers and family members. This current thesis explored the experiences of attending ward rounds for adolescents and parents attending an inpatient mental health unit.

Literature Review

The current review considered the literature examining experiences of ward rounds for service users, carers and family members. Both medical and psychiatric ward rounds were reviewed in a variety of settings. Existing literature indicates that ward rounds are experienced differently for service users and their carers; the former more likely to report feeling intimidated, particularly in psychiatric settings, whilst the latter expressing reassurance received from the process

Research Report

The current qualitative study was conducted to explore the experiences of ward rounds for adolescents and parents attending an inpatient mental health unit. Semi-structured interviews were undertaken with ten participants. A grounded theory approach generated a process model with the core category of 'Adaptation'. The main categories were termed: 'Anticipating'; 'Managing Immediate Impact'; 'Seeking Understanding'; 'Readjusting Expectations' and 'Further Consolidation of Experiences'. Adaptation permeated all these categories.

The model was cyclical in nature as readjusted expectations regarding ward rounds led to a new form of anticipation, before the process started over again. The model described how participants adapted to both the process and contents of ward rounds. A number of elements identified in the study may be more broadly applicable to clients attending ward rounds in other settings.

Critical Appraisal

The research process and the author's personal journey were reviewed. Issues such as the author's background and knowledge gained as both a researcher and a clinician are considered.

(Word count: 297)

Paper One

Literature Review

**A Literature Review of Service Users' and Carers'
Experiences of Ward Rounds in Medical
and Psychiatric Settings.**

Target Journal – British Journal of Clinical Psychology

(Please refer to Appendix 1 for Instructions for Authors).

Note on style

This literature review has been written with a view to submission to the journal, British Journal of Clinical Psychology. Guidelines for authors have been followed where possible unless they contravene specific requirements of formatting and structure for thesis submitted in partial fulfilment of the doctorate in clinical psychology.

A LITERATURE REVIEW OF SERVICE USERS' AND CARERS' EXPERIENCES OF WARD ROUNDS IN MEDICAL AND PSYCHIATRIC SETTINGS.

ABSTRACT

Purpose: Numerous studies have explored patients' experiences of medical consultations and the process of doctor-patient interactions to investigate which communication behaviours are related to patient satisfaction (for a review see Williams, Wienman & Dale, 1998). Yet, despite ward rounds (WRs) playing a major role in planning and evaluation of treatment in both medical and psychiatric inpatient settings, there remains a dearth of literature exploring patients' experiences and satisfaction with this process. This review aims to provide a systematic search and narrative analysis of the relevant literature in this area.

Method: Articles focusing on the experiences of WRs in both medical and psychiatric settings were systematically searched for the timeframe 1950-2007. Experiences of service users (SUs), carers, and family members were included. Fourteen abstracts focusing on ward round (WR) experiences were retrieved and data from eight relevant studies fulfilling the inclusion criteria were scrutinised.

Results: Studies identified were conducted in adult mental health, acute psychiatry, paediatrics, general medical and dementia care. The majority of studies reported positive experiences of carers but more negative views from SUs. Experiences of medical WRs were reported more positively than psychiatric WRs. Problems associated with research in this domain include: a failure to relate findings to theory/literature; inconsistencies in measurement of experiences; small sample sizes; and inadequately validated questionnaires.

Conclusion: There has been scant systematic detailed research into SUs and carers' experiences of WRs and research to date has produced mixed findings. Existing literature indicates that WRs are experienced differently by SUs and their carers; the former more likely to report feeling intimidated, particularly in psychiatric settings, whilst the latter typically express reassurance received from the process.

Keywords: ward rounds; experiences; medical, psychiatric, patients;
service users; carers, family members.

Target Journal: British Journal of Clinical Psychology

(Word Count 299)

PART 1: INTRODUCTION, AIMS AND PROCESS OF THE LITERATURE REVIEW

1.1 Ward Rounds

Ward rounds (WRs) have been an implicit part of the hospital experience for many years and are integral to care in both medical and psychiatric inpatient settings (Seo, Tamura & Morioka, 2000). The general purpose of the ward round (WR) is to review service users' (SUs) care, plan treatment, evaluate progress and plan for discharge (Wagstaff, 2003). In some settings WRs may also serve as information sources for carers and family members (Bains & Vassilas, 1999). WRs are variably staffed and participants may include Consultant and junior medical staff, Nurses, Social Workers, Occupational Therapists, Clinical Psychologists and students from a range of disciplines, with numbers present typically varying from four to twelve dependent upon setting (Seo et al, 2000).

WRs have been examined focusing variously upon: their use as educational fora; as communication media between staff; and, to a much lesser extent, how WRs are experienced by SUs (Wagstaff, 2003). Generalisation about experiences of WRs is difficult since settings, function and process vary (White & Karim, 2005). However, common to most WRs are their weekly feature in multidisciplinary settings generally with the service user (SU) present, and a review of the previous week's care (Seo et al, 2000). Several concerns have been highlighted by SUs regarding WRs (Highland Users Group, 1997) and a code of conduct for WRs has been proposed as a result (Wolf, 1997). This suggests ensuring that WRs are held on time, that a maximum of four staff are present and that introductions are always made by staff unfamiliar to SUs.

1.2 Aims of the Literature Review

This review aimed to provide a systematic search of the published literature and a narrative analysis of relevant papers, focusing on experiences of WRs for SUs, their carers, and family members who attend them, and in doing so to:

- Critically appraise the literature on attendees' experiences of WRs
- Identify common themes in the existing literature
- Examine potentially different experiences of SUs and their carers
- Provide an overview of the quality of research in this area
- Identify gaps in the current literature and suggest areas for further research

1.3 Method

1.3.1 Search terms used

Search terms were first defined as: 'experiences of ward round/s'; 'service user/s AND ward round/s'; 'carers AND/OR families AND ward round/s'. Searches were also conducted using the frequently interchangeable designations applied to patients, i.e. 'consumers', 'clients', and 'service users'. The combination of these searches yielded a very limited body of literature, so focus was broadened to include all articles in which ward round/s featured in the title.

Once search terms were defined, they were entered into the following databases for the timeframe 1950 to 2007: Psycinfo; Embase; Cinahl; Medline; and ISI Web of Knowledge. The breadth of databases used was selected since the area under review was one anticipated to have relevant literature from disciplines other than psychology. No initial exclusions were made regarding publication year and journal, permitting a comprehensive appraisal of the available literature.

1.3.2 Internet Searching

After exhaustive database searches, a broader Internet search was conducted using the Google search engine to highlight articles that although not published in accredited journals, might still provide pertinent context.

1.3.3 Search selection

Initial searches yielded 14 articles relating to SUs and carers' experiences of WRs. The broader search, for articles with 'ward round/s' in the title, yielded 96 papers of which 11 were duplicates. The 99 abstracts (14 original and 85 obtained from the broader search) were then read in full and subjected to the following inclusion criteria:

- Population – SUs, carers, family members and friends who had attended a WR in either a medical, surgical or psychiatric setting
- Methodology – both quantitative and qualitative research papers
- Sample Size – studies using a range of sample sizes were included
- Outcomes – no criteria for outcomes were set as the aim of the review was to identify all outcomes/experiences that had been reported

The following exclusion criteria were applied:

- Papers published in languages other than English
- Publications limited to letters/correspondence/brief commentaries
- Articles referring to inpatient care but with no specific focus on WRs
- Literature focusing solely upon staff members' experience of WRs

1.3.4 Paper retrieval

After having scrutinised the additional articles generated from the broader search with WR in the title, and applying the aforementioned inclusion and exclusion criteria, it was found that none were suitable to be included in the review. However, the process of the broader search was useful in that it ensured that the search had been sufficiently exhaustive. The exclusion criteria resulted in a final collection of eight relevant papers that were included for analysis in this review.

1.4 Results

1.4.1 Summary of studies

Table 1 shows a summary of the main characteristics of each study included in the review. The literature review yielded eight published studies looking at experiences of WRs for SUs and their carers. These comprised three based on medical WRs, and five on psychiatric WRs. Four papers reported solely on WR experiences of SUs (Armond & Armond, 1985; Foster, Fallowski & Rollings, 1991; Wagstaff, 2003; and White & Karim, 2005). Two articles considered the experiences of carers or family members (Bains & Vassilas, 1999; Bramwell & Wiendling, 2005). Two articles used mixed samples to examine WR experiences of SUs, their carers/family members and members of staff (Birtwistle, Houghton & Rostill, 2000 and Rotman-Pikielny, Rabing, Amoyal, Mushkay, Zissin & Levy, 2007). WR experiences of staff members will not be discussed as it is not the focus of this review.

Table 1: Main characteristics of eight studies in the literature review

ID	Reference and where published	Sample Size & population	Medical/ Psychiatric	Methodology/ Analysis	Outcomes
1.	Rotman-Pikielny, P. Rabing, B., Amoyal, S., Mushkay, Y, Zissin, R. & Levy, Y. (2007) Participation of family members in ward rounds: Attitude of medical staff, patients and relatives. Patient Education and Counseling, Vol 65(2), Feb 2007. pp. 166-170.	N = 101 Patients N = 35 Family N = 35 Members Staff N = 26 Israeli Study	Medical	Questionnaire Survey	Looked at the views of having family members present at ward rounds. Patients were keen to have family members present. Staff were reluctant at first but became more positive towards the idea.
2.	Bramwell, R. & Wiendling, M. (2005) Families' views on ward rounds in Neonatal units. Archives of Diseases in Childhood Neonatal Edition, 90, 429-431.	N = 86 Families of babies in neonatal ICU UK Study	Medical	Telephone Survey	Examined experiences of ward rounds- seen as a good source of information but some SUs requested more details before they attended. Some participants were concerned the ward rounds could be overheard. Communication between staff and patients during ward round is essential.
3.	White,R. & Karim, B. (2005) Patients' view of the ward round: a survey. Psychiatric Bulletin, 29, 207-209.	N = 100 Inpatients across 4 wards UK Study	Psychiatric	Self completed Questionnaires	Some patients felt anxious before/ during ward rounds. Some disliked being seen in their own rooms, others disliked large ward rounds, most preferred an exact time to be seen at.

ID	Reference and where published	Sample Size & population	Medical/ Psychiatric	Methodology/ Analysis	Outcomes
4.	Wagstaff, K. (2003) Inpatient experiences of ward rounds in acute psychiatric settings. Nursing Times, Vol.99, No.05, 11-18	N = 8 Adult patients, White British, 5 females, 3 males UK Study	Psychiatric	Semi-structured interview in person, Analysed using Content Analysis	Identified two major categories relating to internal and external processes. Internal processes relating to participants feelings and external processes relating to decision making, communication number of staff present and practical arrangements.
5.	Birtwistle, L., Houghton, J.M. & Rostill, H. (2000). A review of a surgical ward round in a large paediatric hospital: does it achieve its aims? Medical Education, 34, 398-403.	N = 84 Surgeons = 16 Nurses = 30 Patients = 14 Parents = 24	Medical	Open ended interviews to generate a questionnaire	Surgeons see ward rounds playing a valuable role. Nurses dissatisfied with many aspects of the ward rounds. Most patients expressed neutral views but a minority were concerned about confidentiality and levels of anxiety for children.
6.	Bains, J. & Vassilas, C.Q.. (1999) Carers of people with dementia: their experiences of ward rounds. Aging & Mental Health ,3, (2), 184-187	N = 67 Carers of people with dementia. UK Study	Psychiatric	Telephone based questionnaire	Most carers found the ward round a positive experience but some needed to know more about the purpose and composition of the ward round before attending.

ID	Reference and where published	Sample Size & population	Medical/ Psychiatric	Methodology/ Analysis	Outcomes
7.	Foster, H., Fallowski, W., & Rollings, J. (1991). A survey of patients' attitudes towards inpatient psychiatric ward rounds. International Journal of Social Psychiatry, Vol 37(2), pp. 135-140.	N = 50 Inpatients from two wards UK Study	Psychiatric	Semi-structured interviews	Approx 3/4 had at least a moderately favourable impression of the ward rounds but half would prefer not to be interviewed that way. Levels of anxiety and perceived helpfulness were positively correlated. Groups finding it least helpful were Afro Caribbean's and males.
8.	Armond, J.R. & Armond, A.D (1985) Patients' Attitude to Multi-Disciplinary Psychiatric Assessments. British Journal of Clinical and Social Psychiatry, Vol 3, 36-41.	N = 152 Phase 1 = 100 Phase 2 = 52	Psychiatric	Questionnaire Survey	Over one third of participants felt unacceptably anxious or concerned about confidentiality. Ensuring introductions were made by all staff present at ward rounds reduced levels of anxiety from 31% to 15%. Levels of concerns regarding confidentiality remained at 19%.

1.4.2 Design

Of the eight identified articles, five were questionnaire surveys and three used interview techniques to gather data. In order to generate relevant topics for the questionnaires and interviews, researchers either consulted previous literature or held discussions with members of medical staff to generate relevant themes.

1.5 Quality Checks

Quality checks applied comprised: representativeness of the sample size; validity of measures used; and generalisability of findings. Issues regarding quality will be discussed in part three of this review.

PART 2: FINDINGS OF THE LITERATURE REVIEW

2.1 Studies Focusing on Service Users' Experiences of Ward Rounds

Four papers reported solely on SUs experiences of WRs (Armond & Armond, 1985; Foster, Fallowski & Rollings, 1991; Wagstaff, 2003; White & Karim, 2005). All articles were UK-based studies of adult psychiatric SUs.

The first study identified in this review aimed to establish whether the presence of staff in the WR produced anxiety in SUs and affected disclosure of their personal concerns (Armond & Armond, 1985). Completed in two phases the study attempted to elicit SUs experiences of regular multi-disciplinary psychiatric WRs. In the first phase 100 SUs, about to be discharged from various psychiatric units, completed questionnaires about their WR experience. For those holding a generally unfavorable WR experience, no relationship between demographic details, diagnoses and previous hospital experience was found. Yet, a third of SUs reported feeling unacceptably anxious or concerned about confidentiality. This was irrespective of the type of psychiatric unit, or number of people attending the WR, but related to having insufficient knowledge of some staff members present. In the second phase a policy of introducing everyone present to all SUs reduced the proportion of SUs reporting marked anxiety (from 31% to 15%), although concerns about confidentiality remained constant at 19%. The authors concluded that it was not volume of staff present that proved difficult for SUs, but anxieties relating to unfamiliarity with staff present and consequent concerns about confidentiality.

A further study deployed semi-structured interviews with 50 SUs, under psychiatric care in a socially deprived and ethnically diverse area of London (Foster, Fallowski & Rollings,

1991). Interviews were conducted within 24 hours of SUs having attended their first WR and by a research nurse detached from the clinical team and who did not attend WRs. Only half of this sample reported prior knowledge that they would be seen in the WR, and unsurprisingly the majority (72%) felt only slightly prepared. SUs experienced certain factors as particularly difficult including a lack of awareness of: the focus of questions; time the WR would take place; and composition of staff present. Familiarity with staff was also found to be an important determinant of WR experiences with 68% of SUs recognising only a quarter of the people present. However this is a possible artifact of the interview having been conducted within 24 hours of SUs admission. Mixed findings were reported on whether SUs preferred unfamiliar staff to make introductions and for some SUs having unfamiliar staff present resulted in a more negative and overwhelming WR experience. For the majority of SUs neither staff status nor number appeared to relate to general WR experience, perceived helpfulness, and levels of anxiety or concerns regarding confidentiality. Nevertheless, given the choice of being seen in the WR or not, 58% expressed a preference for their care to be discussed in some other way.

Perception of WR helpfulness was positively correlated with the general impression and level of anxiety for 74% of participants. A novel finding emerging from this study was the suggestion that those SUs who found the WR more helpful were also more likely to be anxious. This group typically asked more questions and took their own agendas to WR suggesting that either a moderate amount of anxiety may be inevitable if WRs are to be experienced as helpful or that anxiety acts as an impetus to plan for the WRs in advance. Forty two percent reported moderate anxiety during WR whilst 32% were not anxious at all. Not surprisingly, unmanageable levels of anxiety were not seen as productive. The authors state that there was a significant correlation between being given a full explanation of the

purpose of the WR and remembering its contents. Regarding anxiety, 42% were moderately anxious during WR whilst 32% were not anxious at all. Male SUs found the WR less helpful than females and SUs from Afro-Caribbean backgrounds found WRs less helpful, less memorable and less understandable than other SUs.

Eight psychiatric SUs were interviewed in a qualitative exploration of their experiences of WRs (Wagstaff, 2003). Two major themes were identified: internal and external processes. Internal processes described SUs subjective feelings about the WR and an evaluation of the experience with a focus on: positive and negative experiences of WRs; outcomes, and consequences of WRs; as well as coping strategies adopted. External processes comprised four sub categories: decision making; communication; number of staff present; and practical arrangements. Wagstaff commented that the findings indicated several areas of satisfaction with WRs, amongst which was their potential to be confidence building for some SUs. However, all SUs made some reference to feeling intimidated with reasons including: number and status of staff present; seating arrangements; and being expected to contribute at WRs.

It appears that in the Wagstaff (2003) study, WRs were seen as a fearful and intimidating process when viewed in terms of power differentials between SUs and staff groups. No SUs reported feeling part of the decision making process; this is likely to have increased the likelihood of them reporting a negative WR experience. The high numbers of professionals present was not perceived as reassuring as is reported in some medical settings (Seo et al, 2000) but was commonly felt to be excessive. It was also reported that a majority of SUs felt anxious before entering the WR.

Quantitative evaluation of psychiatric SUs experiences of WRs was conducted by White & Karim (2005). The research was undertaken in order to audit WRs and utilised a self-completed questionnaire constructed after consultation with medical staff and comprised two sections, the first relating to the conduct of the WR, and the second focusing on SUs subjective experiences of the WRs.

One of the strongest determinants of a positive WR experience for SUs was having a specified time for participation in the WR that was adhered to (White & Karim, 2005). This was significantly more important for the SUs in the age-band 25-44, compared to SUs in younger and older age categories. Fifty four percent of SUs did not like more than four people present; this was more apparent for females than males (with younger females being particularly averse). The presence of family members was disliked by 41% of SUs. Similarly 41% of SUs reported a more positive experience at WRs when seen in their own room, compared to 22% who preferred to be seen in a clinic room on the ward. Young females were the group of respondents most likely to dislike being seen in their own bedspace. The majority of SUs (58%) reported that they often felt unable to express their feelings during WRs; this was associated with age, with the youngest SUs feeling least able to express their feelings. Anxiety levels were reported as being high for most SUs before the WR, with this being particularly so for females.

2.2 Studies Focusing on Carers'/Family Members' Experiences of Ward Rounds

Two papers included a focus solely on WR experiences for carers/family members within dementia care (Bains & Vassilas, 1999) and neonatal care (Bramwell & Wiendling, 2005).

To examine the WR experiences for carers of people with dementia, researchers administered telephone questionnaires to 67 participants to determine if WRs were experienced as more stressful for spouses than other carers (Bains & Vassilas, 1999). The sample consisted of spouses and a variety of carers/family members who had contact with psychiatric services for older adults in the UK. The mean time between attendance at WR and telephone interview was 29 weeks. The questionnaire was a non-standardised nine-item design constructed by the department's clinical psychologist and focused on carer's subjective experiences of WRs.

The majority of spouses and carers (58%) reported finding the WR a positive experience, however a substantial minority (42%) of spouses reported experiencing the WR as stressful. Comparisons with other carers, however, were not statistically significant and it was not stated how stress was operationalised. Reassurance appeared to be related to the number of professionals involved in their relative's care. A third of participants reported concerns relating to a lack of information regarding the WR agenda or which staff would be present, highlighting the importance of initial preparation for SUs and their carers.

Bramwell & Wiendling's (2005) UK-based study explored WRs in a neo-natal intensive care setting, which usually comprised of between 8 and 10 people standing around the baby's cot. A telephone survey of 86 regional neonatal units generated relevant themes that were converted into a short structured interview including both open and closed questions. Parents were interviewed individually, and grandparents and partners other than genetic parents were also eligible for inclusion. It was not stated who conducted the interviews.

Again, a major determinant of less positive WR experiences for participants was a lack of information about the timing and nature of the WR. Uncertainty regarding timing issues prevented some parents from attending and parents who were unaware that WRs were occurring found it a particularly stressful experience to see high numbers of staff around their baby's cot. By contrast positive experiences were noted as a function of information giving acting as a source of reassurance. The majority of parents (86%) expressed a desire to hear what the doctors had to say at WRs but a minority (7%) found it difficult to talk to a large group of doctors. Although poorly operationalised, quality of interaction with medical staff was an important determinant of the parent's experience, in particular relating to whether or not the parents felt included by the doctors.

Other factors apparently contributing to a negative WR experience included the use of medical terminology and concerns that confidential material was discussed within earshot of other families. Twenty per cent of parents expressed concern and 16% felt embarrassed when overhearing conversations about other peoples' babies. However, whilst some were concerned this was a breach of confidentiality; others reported it being a positive experience to hear other babies were progressing well.

2.3 Studies Focusing on Mixed Samples Experiences of Ward Rounds

Two studies recruited mixed samples of SUs, carers/family members and staff (Birtwistle, Houghton & Rostill, 2000; Rotman-Pikielny, Rabin, Amoyal et al, 2007).

As WRs feature so prominently in the inpatient experience for many SUs, it is of fundamental importance that they reach their aims. Birtwistle, Houghton & Rostill (2000) surveyed parents and their children on a medical ward in a UK-based children's hospital to

determine if these groups felt the WR met its aims. The aims were specified as: to provide a learning experience, aid clinical management and decision making, and to ensure that staff on duty at the weekend are aware of the patients needs. It was also stated that WRs provided an opportunity to share ideas on specific cases. Relevant themes were generated by interviewing medical staff to gain their views on the surgical WR. The questionnaire utilised a Likert rating scale to measure responses to several themes including SUs personal WR experiences and more practical matters (such as timing and seating arrangements etc). Questionnaires were administered by an Assistant Psychologist.

Regarding the experiences of parents, 58% reported that they found it encouraging to see so many doctors discussing their child and 66% appreciated the opportunity to ask questions, which was linked to a more positive WR experience. However some parents felt the WRs made their children anxious. For teenage SUs, 60% of adolescents found it encouraging seeing many doctors discussing their care but three admitted to feeling anxious upon their arrival. Overall, the vast majority of teenagers (80%) reported ambivalent feelings about WRs. This was similar for the youngest age group where 77% reported fairly neutral feelings regarding their WR experience. Only a small number reported feeling anxious about WRs but most SUs in the youngest age group found it difficult to understand what the doctors were saying.

As family members are often present during WRs it appeared important to experience how having them present is experienced by both SUs and the family members themselves (Rotman-Pikielny, Rabin, Amoyal et al, 2007). A two phase study was utilised to explore WRs conducted both with and without family members present (phases 1 and 2 respectively).

Questionnaires designed by a Physician, Social Worker and Medical Statistician contained between 10 and 15 questions with variable rating scales and were administered during both stages. Different groups of SUs and family members completed the questionnaires at phases 1 and 2. SUs were asked about their interest in family members' presence during WRs, and the perceived benefits of this. Family members were asked to express their preference about being present during WRs, whether it would aid their understanding of their relative's care /disease, and if being involved in the decision making process reduced anxiety.

Results indicated that although most SUs described the WR as a positive and instructive experience, many felt frustrated by their inability to understand the medical terminology used. Both SUs and family members found the presence of family members at WRs reassuring. SUs reported that the presence of family members aided communication with staff. For family members the most positive aspects of WR experiences was being involved in the decision making process.

2.3 Summary of Reviewed Papers

The studies examined in this review are typically impressionistic and have demonstrated variability in experiences. More positive experiences emerge from medical WRs than psychiatric, and WRs are more likely to be experienced as reassuring by carers than SUs. Young SUs appeared to report fewer negative experiences than adults, and females found WRs more distressing and challenging than do males. Factors that appear to reassure carers are the number of people involved in their relative's care (also a reassuring factor for some teenagers regarding input into their own care). WRs are also seen as a useful process to share information and be engaged in the decision making process for some carers and families. Areas predictive of a more negative ward round experiences include: lack of

awareness of questions; the unpredictable nature of WRs; uncertainty about timing of the WR and numbers of staff present. This uncertainty appears to produce anxiety for less confident SUs. Confidentiality issues appeared as a concern for some SUs.

PART 3: CRITIQUE OF STUDIES EXAMINED IN THE CURRENT REVIEW

3.1 Critique

Whilst the studies examined suggest tentative and partial insights into experiences of WRs they are limited and flawed. This review will now provide a critique of these studies before turning to a more general critique of the problems associated with measuring complex phenomenon such as SUs experiences, and general satisfaction with health care.

3.1.1 Research Design in Reviewed Studies

The quantitative surveys described are advantageous in their ability to tap into more tangible aspects of WRs. However, they lack the ability to provide a detailed exploration of subjective responses and self-generated elaboration of the answers SUs provided are thus precluded (White & Karim, 2005). The qualitative study deployed by Wagstaff (2003) permitted more detailed exploration of responses via the use of content analysis, however, the study remains limited by the relative superficiality of the approach which does not permit theory construction, as would be possible with Grounded Theory (Glaser & Strauss, 1967).

A number of the studies were also limited by the way in which the questionnaire was constructed. Questionnaires were frequently constructed in consultation with medical staff but without input from SUs representation, possibly omitting key themes relevant to SUs (White & Karim, 2005; Birtwistle, Houghton & Rostill, 2000). Whilst Birtwistle, Houghton & Rostill (2000) included both closed and open ended questions that offered a less restricted way for participants to express their experiences, it is not clear to what extent this qualitative data was subject to in-depth analysis or if any appropriate methodologies to analyse such

qualitative data such as Template Analysis (King, 2004) were utilized. Finally, a more general limitation of the reviewed studies was the lack of measurement and control for other input factors (e.g. patients' mood state) that are likely to influence the WR experience and satisfaction rates.

3.1.2 Reporting of Procedures in Studies Reviewed

Researching SUs experiences of WRs can be problematic if done by a member of the clinical team present at WR. In such instances SUs may feel unable to express negative views in fear that doing so may affect their treatment or care (Wagstaff, 2003). SUs may also be more likely to acquiesce to give a favorable view of themselves to the researcher. It is thus advantageous to use a researcher independent to the team to carry out such research. Foster, Fallowski & Rollings (1991) used a research nurse unknown to the clinical team to remove potential bias in data collection and analysis. Similarly, Birtwistle, Houghton & Rostill (2000) employed an Assistant Psychologist to conduct data collection. Both of these studies go some way to removing this potential problem. Armond & Armond (1985) used three different research assistants to administer questionnaires which is problematic as variation in style of administering the questionnaire and differing degrees of assisting participants may have confounded the results.

A further confounding factor relates to studies that use SUs from different wards within the same research, since any reported differences could be attributable to different consultancy style, or variation in WR process or structure rather than experience per se (Armond & Armond, 1985; Foster, Fallowski & Rollings, 1991; and Armond & Armond, 1985). Whilst these various researchers

acknowledge this as a potential confounding factor, they offer no solutions to remedy the issue.

3.1.3 Reporting of Eligibility Criteria in Reviewed Studies

Most studies provided an adequate description of their sample, however, few provided sufficient detail regarding eligibility or inclusion/exclusion criteria. For example, it is not stated if SUs had to have attended a certain number of WRs, if age restrictions regarding recruitment were employed, or if any other restrictions were made (e.g. for SUs with a diagnosed learning disability or sectioned under the Mental Health Act (Department of Health, 2001). One exception was the study conducted by Armond & Armond (1985) which excluded on ethical grounds SUs who had received a section.

3.1.4 Power and Sample Size in Reviewed Studies

Sample sizes of SUs in the reviewed literature varied enormously ranging from eight (Wagstaff, 2003) to 100 (White & Karim, 2005). None of the studies reported *a priori* power calculations in relation to their sample size. Power calculations are advantageous in that they provide an estimation of the ability of a given study size to provide a measure of relative risk within a preset limit of precision, or with a preset likelihood of providing a false positive and false null finding. Therefore, for the larger scale studies in this review, a power calculation would have increased the robustness of the findings.

3.1.5 Reporting of Procedure & Findings in Reviewed Studies

Clarity and parsimony were absent in some studies. Bramwell and Wiendling (2005) reported their findings vaguely in terms of ‘some respondents’ and ‘the majority’ without

stating the relevant percentages. Similarly, Bains & Vassilas (1999) reported differences in levels of stress and WR experience between carers and spouses, which would have benefited from a more detailed description of how stress was operationalised to more fully explain the findings.

3.1.6 Standardisation, Validity and Reliability of Measures Used in Reviewed Studies

Survey and questionnaire methodologies appear a popular measurement tool in the area under review, yet often these were not subject to any form of standardisation or validation. Whilst, Birtwistle, Houghton & Rostill (2000) did subject their questionnaires to inter-rater reliability checks, statistical validation was not undertaken. Insufficient details of such checks were provided in the other studies reviewed.

Questionnaire methodologies become problematic when biased response scales are deployed as evidenced within Armond & Armond (1985) where more responses indicative of a favorable than unfavorable WR experience were constructed in the questionnaire. Concerns about the validity of findings from this study are also raised when different groups of SUs and family members complete questionnaires in different phases of the research. This prevents valid comparisons between the two phases as differences may be due to variation between the two samples rather than differences in WR experiences.

3.1.7 Generalisability of Studies Reviewed

Generalisability is an important factor when considering the usefulness of research studies. Extrapolation to wider populations can be problematic when small sample sizes are either small or heterogeneous in nature. Differences in length of patient stay, consultants' age, cultural and ethnic background of SUs and their diagnoses may have all affected

experiences of WRs and prove problematic when trying to generalise findings.

Furthermore, some of the studies reviewed were conducted either using small sample sizes (the qualitative sample of eight participants by Wagstaff, 2003), or in specialist settings: a neonatal ICU unit (Bramwell & Wiendling, 2005); a single medical ward in Israel (Rotman-Pikielny et al 2007) and the qualitative sample of eight participants (Wagstaff, 2003).

3.1.8 Time Frame of Studies Reviewed

The point in time at which SUs are approached to describe their WR experiences is also worthy of consideration. Within the studies reviewed this varied immensely. Foster, Fallowski & Rollings (1991) conducted their interviews with SUs within 24 hours of them having attended their first WR during the first week of admission, which did not provide much time for participants to have settled in, or become familiar with staff. Armond & Armond (1985) recruited SUs who were being discharged the following day. This could have been problematic in that being aware that their discharge was imminent could have resulted in a concern that expressing negative views would prevent this from taking place. Other studies were carried out after SUs had been discharged with Wagstaff (2003) sampling SUs within a week of discharge and of having attended their last WR. The longest period between attending a WR and recounting their experiences was 29 weeks in the Bains & Vasillas (1999) study. It is possible that the accuracy of recall after such a prolonged period may be questionable when one considers the accuracy of retrieval from long term memory (Lindsay & Norman, 1977).

3.1.9 Application of Findings to Relevant Theory

One of the main difficulties with all of the reviewed studies is their failure to relate findings either to existing theory or to generate new theory. For example, anxiety is variously

operationalised in each of the studies, but is not related to any models of anxiety, e.g. health anxiety or generalized anxiety disorder (Wells, 1997) to inform the explanation given for the findings. Nor do they provide a detailed account of the form it takes, thus overlooking the causes, triggers and consequences of the anxiety. This is arguably due to the basic nature of the studies under review.

PART 4: METHODOLOGICAL ISSUES IN MEASURING EXPERIENCES AND SATISFACTION WITH HEALTH CARE

4.1 Introduction

The purpose of this piece of work was to review the literature examining experiences of WRs for SUs and their carers or family members in diverse settings. However, from the process of reviewing the literature, it became clear that measurement of SUs experience shares many problems with those relating to the measurement of satisfaction with health-care more generally. Particularly problematic are adequate definitions of satisfaction; as this is rarely defined. In conducting this review and considering the concept of satisfaction the author could find scant evidence as to what this means to either those researching the area or those who complete such surveys.

Furthermore, it is well documented that attempts to measure patient satisfaction with any aspect of health care is a political, complex and problematic issue (Cohen, Forbees & Garaway, 1996). A number of issues are relevant here, including: implications of who the research is funded by (e.g. expansion of or withdrawal of services); and SUs potentially expressing a negative opinion about the care they are still in receipt of. However, it remains that understanding SUs and carers' experiences of inpatient psychiatric care and WRs is an important clinical task, since the experience of these phenomena is a critical determinant of satisfaction and health outcomes (Thorsen, Witt, Hollnagel, & Malterud, 2001).

4.2 Research Methodologies Used to Measure Patient Satisfaction and their Experiences

Unlike studies examining experiences of general consultations, which are largely reliant on satisfaction surveys, those examining inpatient care and WR experiences have used a

mixture of qualitative and quantitative research tools (Goodwin, 1999). A large body of literature focuses on the reliability and validity of the methodologies used to measure satisfaction and their associated strengths and weaknesses. It is stressed that there is a particular need for a standardised, validated measurement tool (Cohen, Forbees & Garaway, 1996) able to measure the multi-faceted phenomenon of satisfaction. This review will now discuss the strengths and weaknesses of the methodologies used in measuring SU satisfaction and experiences.

4.3 Survey Methods

Self-completion questionnaires used to measure satisfaction are argued to have value because they enable the more tangible aspects of care to be measured (Wagstaff, 2003). Research questions about the more pragmatic aspects of social care such as environment, car parking and food are easier to operationalise (White & Karim, 2005). However, when trying to elicit experiences about the more abstract aspects of care (such as experiences of care as an inpatient or via WRs), issues are more complex. A further advantage of survey methods is that they enable large samples of respondents to be targeted, yield quantitative data which can be generalised and can serve as future predictors of levels of satisfaction and dissatisfaction (Cohen, Forbees & Garaway, 1996).

Although standardisation is important, the costs and weaknesses of surveys in which restrictions are placed on the responses that can be made (usually a tick box exercise) are evident (Thorsen, Witt, Hollnagel & Malterud, 2001). Such formats restrict the responses that can be given about satisfaction with more multi-faceted and personal matters such as experiences of communication with health care professionals, inpatient care and WRs.

Additionally, by placing uniformity on responses, important information about personal and dynamic experiences may be overlooked.

Survey methodologies also tend to obscure the meanings behind the responses that patients give (Wagstaff, 2003). Indeed, Seo et al (2000) suggest that problems in measurement arise when structured methods of data collection are used to try and identify more abstract aspects of care, of which experiences of WRs would be one example. Furthermore, it has been argued that current methodologies rely on the notion of the SU as a rational evaluator who is willing and able to judge all aspects of hospital care dispassionately and reliably (Cohen, Forbes & Garaway, 1996), and tend to over emphasise cognitive rather than affective issues. Many issues that prove to be difficult for SUs may relate to communication factors and are difficult for SUs to articulate. Such factors may be lost in research that employs methodologies that restricts the responses to pre-determined scales and does not allow the opportunity to explain the reasons provided.

4.4 Qualitative Methods

In the last decade there have been an increasing number of calls for research of a qualitative nature to explore experiences of care received as part of an inpatient stay, including WRs (Wagstaff, 2003; White & Karim, 2005). Qualitative methods of investigation enable in-depth exploration of complex phenomenon and permit the interviewer to pursue and contextualise responses to determine the reasons behind them. These techniques are not without fault as they are inevitably influenced by the power relations between the interviewer and interviewee (Wagstaff, 2003). Some of the problems associated with survey methods are relevant here too. For example, SUs may feel unable to express dissatisfaction and negative experiences regarding the more personal aspects of the care they receive, due

to the fear that doing so may negatively impact on their care or on their relationships with the staff that provide it (Birtwistle, Houghton & Rostill, 2000).

4.5 Problems with Measuring Experiences of Ward Rounds

In addition to the problems already discussed relating to general measurement of patient satisfaction, there are also more specific problems associated with measuring experiences of WRs. For example, it is unlikely that one standardised tool would be able to successfully measure the many different aspects of WRs that a SU would typically encounter.

Furthermore, care received as part of the inpatient process is likely to vary depending upon the setting and the client group in question (e.g. learning disabilities, young people, older adults etc). Similarly, WR experiences may differ depending on the chairing style of the consultant involved (Armond & Armond, 1985; White & Karim, 2005). It is also possible that different questions may be needed for SUs who are receiving inpatient psychiatric care through choice and those whose inpatient stay is enforced by the Mental Health Act (Department of Health, 1983). It is therefore important to consider the social context in which research is conducted when interpreting the findings.

PART 5: DISCUSSION AND SUGGESTIONS FOR FUTURE RESEARCH

5.1 Discussion of Findings

There is an extensive literature on patient satisfaction, doctor-patient communication and the consultation process (Williams, Wienman & Dale (1998) provide a review). However, perplexingly it remains that neither theory, constructs, nor experiences from this body of literature appear to inform research examining SUs experiences of WRs. WRs play a pivotal role in a SUs care in both medical and psychiatric settings. In the current climate there is substantial impetus for SUs to give feedback about the services they receive (Department of Health, 2001) and it is likely that the WRs will remain a regular and important part of treatment for some time to come, highlighting the need for additional research in this area. In order to make WRs a more productive and positive experience for all involved there are a number of issues which are worthy of consideration including: ensuring that information is given to SUs and carers before attending their first WR; encouraging staff that are unfamiliar to SUs to introduce themselves; being aware of levels of anxiety amongst some SUs and carers; ensuring WRs are held in as private a setting as possible to enhance confidentiality; including SUs and carers in decision making when possible and considering more practical arrangements such as timing of WRs; seating arrangement and numbers of staff present.

5.2 Suggestions for Future Research

Primarily, this review has revealed that how SUs and their carers experience WRs is still an open question, highlighting the need for further research of a more robust and detailed nature. To better understand the specific features of WR experiences, researchers would do well to use either mixed methodology or qualitative methods in order to enable a more comprehensive exploration of this phenomenon. Such research could go a long way in

providing an in-depth analysis of SUs experiences of WRs. Crucially, future research should aim to be more theoretically driven and include psychological models to explain the findings, with a specific focus on feelings the WR generates, the psychological impact of attending WRs and how WRs may impact on service-user engagement during inpatient care.

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Paper Two

Research Report

“When in Rome”

**A Grounded Theory Analysis of
Service Users’ Experiences
of Ward Rounds.**

Target Journal: Qualitative Research in Psychology

(Please refer to Appendix 2 for Instructions for Authors).

Note on style

This research report has been written with a view to submission to the journal, Qualitative Research in Psychology. Guidelines for authors have been followed where possible unless they contravene specific requirement of formatting and structure for thesis submitted in partial fulfilment of the doctorate in clinical psychology.

RESEARCH REPORT ABSTRACT

Objectives

The current study was conducted to explore the experiences of ward rounds (WRs) for young people and parents in the context of an inpatient mental health unit for adolescents, and to develop an understanding of the psychological processes involved.

Method

In depth, semi-structured interviews were undertaken with 5 young people and 5 parents who had attended WRs in the identified setting. Transcripts were analysed using grounded theory methodology.

Results

A core category of 'Adaptation' was identified which described the process participants' went through whilst attending WRs. A process model was developed comprising five main phases. These represented participants' anticipation of attending WRs; managing the impact of WRs; attempts to seek out understanding of the WR; and a readjustment of expectations. This fed back into a new form of anticipation indicated that the process model was cyclical in nature. Participants who had been discharged appeared to engage in a further stage of consolidation of experiences after they had left the unit.

Conclusions

There appears to be areas of both commonality and difference in the experiences of attending WRs for young people and parents. Parents typically found the WRs reassuring, whereas young people mostly experienced them as difficult and distressing. However, the process of 'Adaptation' appeared to result in a more positive view of this experience for most young people. The developmental stage of adolescence proved interesting when considering the WRs experience of young people. Literature examining the impact of having a child in inpatient care proved useful when attempting to understand the WR experiences for parents.

Clinical Implications

Results indicated a need to more fully prepare and inform service users before attending WRs; the need to understand the psychological impact of attending and a need for support for those who find this a difficult and distressing experience.

Target Journal: Qualitative Research in Psychology

(Word Count: 299)

CHAPTER 1: INTRODUCTION

1.1 Service Users' Experiences of Consultations

Much time and effort has been devoted to researching service users (SUs) experiences of consultations, in particular those taking place in primary care (Cohen, Forbes & Garraway, 1996; Williams, Wiemann & Dale, 1998;). Studies have highlighted a number of factors as being important in contributing to a positive experience for SUs and their carers, including: effective communication between doctor and patient; Beckman, Kaplan & Frankel, 1989); preparing patients for consultations (Hunter, Grunfeld & Ramirez, 2003); information provision to patients regarding their presenting problem and the consultation process (Williams, Wiemann & Dale, 1998; Goodwin, 1999) and assuring conditional confidentiality is maintained (Birtwistle, Houghton & Rostill, 2000). However, for some SUs consultations remain an unsettling and stressful experience (Highland User Group, 1997; Rutishauser, Esslinger, Bond & Sennhauser, 2003).

1.2 Service Users' Experiences of Ward Rounds

The general purpose of ward rounds (WRs) is to review a patient's care, plan treatment, evaluate progress and plan for discharge (Wagstaff, 2003). In some settings WRs may also serve as an information source for SUs, carers and family members (Bains & Vassilas, 1999; Birtwistle, Houghton & Rostill, 2000; Bramwell & Wiendling, 2005). Composition of staff in WRs varies between settings but typically it includes members of the multidisciplinary team involved in the SUs care.

Experiences of WRs for SUs and their carers has been explored (Armond & Armond, 1985; Bains & Vassilas, 1999; Birtwistle, Houghton & Rostill, 2000; Wagstaff, 2003; Bramwell &

Wiendling, 2005; White & Karim, 2005, Rotman-Pikielny, Rabin, Amoyal et al, 2007).

Findings typically vary between SUs and carers and also between medical and psychiatric care. Wagstaff (2003) states that there remains “ *some uncertainty about how psychiatric inpatients perceive ward rounds, with general surveys of satisfaction indicating negative views, contrary to evidence found in non-psychiatric settings*” (p.31).

Despite WRs being a pivotal part of inpatient care Birtwistle, Houghton & Rostill (2000) state that, “*little objective information is available concerning the activities or outcomes’ of ward rounds*” (p.398). Furthermore, WRs differ from consultations in that the former are often attended by SUs because it is perceived as being part of their inpatient care, rather than a desire to do so as may be the case with a consultation with a general practitioner (Wagstaff, 2003).

1.3 Positive Experiences of Ward Rounds

Literature indicates that a number of factors can contribute to a more positive WR experience for SUs. Ensuring that SUs are not keep waiting for prolonged periods has been indicated as important in reducing anxiety levels (White & Karim, 2005). Preparing SUs for WRs in advance and providing appropriate information about the likely content of WR has also been found to alleviate anxiety which can arise from uncertainty in some SUs (Bramwell & Wiendling, 2005).

Furthermore, many SUs value WRs as they provide the opportunity to be involved in decisions that are made about their care. Wagstaff (2003) quotes one of the participants in her research of psychiatric WRs, “*if they are making decision on my treatment, I’d expect they’d all come to talk to me*” (p.34).

For carer's WRs have been reported to be a reassuring process, mainly related to the input from a variety of health care professionals which can lead to increased optimism about the care their relative is receiving. WRs also serve as an opportunity for family members to ask questions, and their presence can also aid communication for SUs, leading to a more positive experience for all (Foster, Fallowski & Rollings, 1991).

1.4 Negative Experiences of Ward Rounds

The presence of high numbers of staff is typically disliked by SUs, unlike carers, who typically find this reassuring. For many SUs this can lead to increased levels of anxiety. A participant in the Wagstaff (2003) study comments "*there were just too many people, I wanted to talk to one person*" (p.34). Similarly, White & Karim (2005) expressed that ideally four or fewer staff should be present. However, other author's have argued that it is familiarity with staff rather than their numbers per se that determines levels of anxiety (Armond & Armond, 1985).

Regarding the presence of family members at WRs, some SUs have expressed a preference to attend WRs alone (Birtwistle, Houghton & Rostill, 2000). Conversely, family members expressed a desire to be present in order to feel involved in the decision-making process and to increase their understanding of their relative's illness and care (Rotman-Pikielny, Rabin, Amoyal et al, 2007).

Concerns regarding confidentiality have been found to lead to negative experiences of WRs, especially within medical settings (Bramwell & Wiendling, 2005). They suggest this was a concern for parents when WRs were conducted within the hearing of other families. They state "*clinical practice needs to take into account the observation that overhearing and*

being overheard are distressing experiences for some” (p.443). The importance of confidentiality has also been found to be a particular concern for adolescents during psychiatric consultations and Rutishauser, Esslinger, Bond & Sennhauser (2003) suggest that “ *physicians should offer adolescent patients the opportunity to see them alone for some time and assure them of conditional confidentiality, including confidentiality with regards to their parents*” (p.1326).

Finally, difficulties contributing at WRs have been found to be a concern for some SUs, in particular for females (Birtwistle, Houghton & Rostill, 2000). A further factor affecting contribution is the clarity of language used, with some young SUs reporting difficulties understanding the ‘medical jargon’ used (Armond & Armond, 1985; Rotman-Pikielny, Rabing, Amoyal et al, 2007).

1.5 Methodological Issues with Previous Research

The studies discussed have provided interesting, albeit brief insights into what is clearly a highly complex phenomenon. Furthermore, there are various limitations with the studies that warrant consideration. A number of the studies discussed used questionnaires that were not validated (Birtwistle, Houghton & Rostill, 2000; White & Karim, 2005; Rotman-Pikielny, Rabin, Amoyal et al, 2007). Other studies claimed to have reached statistical significance without stating the statistical tests used (Foster, Fallowski & Rollings, 1991).

When studies are conducted in two phases it is important to try and ensure the same participants complete the questionnaires in both stages. When different participants are sampled in the two phase’s results may be confounded by individual differences between the two samples. This was a criticism of the study by Rotman-Pikielny, Rabin, Amoyal et al,

(2007). Having someone not attached to the clinical team running the WR is a distinct advantage in removing potential biases in data collection. However, having different researchers involved in collecting data in the same study can also lead to problems with inconsistency in data collection, as in the study by Armond & Armond (1985). Finally in the study by Bains & Vassilas (1999) SUs were asked to describe their experiences 29 weeks after having attended a WR, raising doubts about accuracy of recollections from long term memory (Lindsay & Norman, 1977).

1.6 Developmental Psychology

As WRs appear to involve processes that can engender a lack of independence and autonomy (Wagstaff, 2003) it would prove interesting to consider how such an event would be experienced by young people in the developmental stage of adolescence. Theories of adolescence describe an increased desire for independence and control over decisions (Geldard & Geldard, 1999), factors that may not always be possible when attending WRs. Similarly, it would also be interesting to explore WR experiences for parents of children in this developmental stage, as the transitional period of adolescence has been demonstrated to be a difficult time for parents also (Puotinieme & Kyngas, 2004).

1.7 Rationale of Current Research

No research to date has provided a theoretical account or an in-depth exploration of WR experiences for young people and parents who attend as part of inpatient psychiatric care. This is an important client group to consider as research indicates having a child in inpatient care is a stressful and anxiety provoking time for all concerned and that high levels of stress and anxiety can impede recovery (Puotinieme, Kyngas & Nikkonen, 1999; Puotinieme & Kyngas, 2004).

1.8 Aims and Objectives

Due to the dearth of research into experiences of WRs for young people and their parents, it seems an opportune area to explore. Given that no theory exists which focuses specifically on how WRs are experienced by SUs, grounded theory seems an appropriate methodology to adopt. This method enables theory generation that in this instance will emerge directly from the accounts of young people and parents attending WRs in an inpatient psychiatric unit for adolescents. Findings will be considered in terms of previous research and psychological theory, something that to date, other studies have failed to do. The specific research questions are addressed in the next chapter of this report.

CHAPTER 2: METHODOLOGY

2.1 The Research Question

The research questions in the current study aimed to explore:

- How do young people experience ward rounds (WRs) in the context of an inpatient mental health unit?
- How do the parents of these young people experience WRs?

2.2 The Research Design

To date, there has been no research that has provided a detailed exploration of SUs experiences of WRs resulting in a dearth of literature and theory in this area. Grounded Theory (GT) was therefore felt to be the most suitable approach as when compared to other qualitative methods, e.g. Interpretative Phenomenological Analysis or Discourse Analysis, it is better placed to provide a theory-generating exploration of participants' accounts.

2.3 Grounded Theory

GT aims to develop a theory that is grounded in the data under analysis and is considered an inductively-driven process (Strauss & Corbin, 1998). Glaser and Strauss (1967) stressed the importance of understanding the ways in which people make sense of and construct their own realities. More recently Charmaz (2006) commented that GT enables the researcher to *"make analytic sense of their meanings and actions"* (p.11). Theory underpinning GT differs epistemologically from both quantitative research and other qualitative methods in that data collection and analysis occur simultaneously. Due to word constraints, further details on GT are contained in Appendix 3.

2.4 Procedure

2.4.1 Ethical approval

Ethical approval for the study was sought and obtained from the Leicestershire Research Ethics Committee, and the Host Trust. The study was approved as being compliant with NHS governance procedures. Copies of the letters granting ethical approval can be seen in Appendices 4 and 5.

2.4.2 Recruitment of Participants

Young people who were current residents or had been resident in an inpatient adolescent mental health unit over the past year were eligible for recruitment. Parents (genetic, adopted and legal guardians) of current and former residents over the same timescale were also eligible to participate. Potential participants were identified by the ward manager or the head of service. Contact was initiated by an administrator within the service who sent potential participants an information pack, containing a letter of invitation, information sheet and opt in form (see Appendices 6-8). Interested respondents returned a completed expression of interest form and were contacted by the researcher to arrange an interview.

2.4.3 Inclusion Criteria

Young people and parents who had attended at least one WR round during the past year were eligible for inclusion. It was hoped this would ensure relatively easy recall of WR experiences.

2.4.4 Exclusion Criteria

The following groups were excluded: children under 14 years; (based on the literature suggesting that such children are less likely to understand complex, abstract questions

(Inhelder & Piaget, 1958). Children with a formal diagnosis of a learning disability prior to entering the unit; (as advised by the researcher's field supervisor due to concerns that being asked potentially complex and distressing information may prove distressing for this group). Young people and parents identified by the ward manager as experiencing current high levels of distress were also excluded.

2.4.5 Description of Participants

A breakdown of the final sample can be seen Table 2.

Table 2: Description of Participants

Interview No	Young Person/ Parent	Gender	Current/Former Resident	No of Participants
1	Young person	Female	Former	1
2	Young person	Female	Former	1
3	Parent	Female	Former	1
4	Parent	Male	Former	1
5	Young person	Male	Former	1
6	Young person	Male	Current	1
7	Parent	Male	Current	1
8	Young person	Female	Current	1
9	Parents	Male/Female	Current	2
Total 9 Interviews	5 Young People 5 Parents	5 Males 5 Females	5 Current 5 Former	Total 10 Participants

2.4.6 Data Collection

Data was collected between October 2006 and March 2007. All interviews were conducted in person by the researcher at a location of the participant's choice. All 9 interviews were tape recorded and transcripts are bound separately and contained as an addendum.

2.4.7 Data Management and Transcription

Interview material was transcribed verbatim by the researcher in order to enhance immersion in the data. Identification of interviewer was represented by the researcher's

initials (KC) and for participants a pseudonym was used. Each line of text was numbered in order to identify relevant quotations (e.g. see “Danni”, Line 128). Pauses above three seconds were presented in brackets (e.g. Pause 7 seconds). Tapes were kept in a secure location to which only the researcher had access, where they will be kept for five years post research completion and will then be destroyed.

2.4.8 Confidentiality

The sensitive nature of the data required stringent measures to be taken to ensure confidentiality of the information and presentation of results. All identifiable data were anonymised during transcription and names of the participants, staff, family members and other identifiable data such as job titles etc were anonymised to ensure confidentiality.

2.4.9 Interview Procedure

Participants were given an opportunity to ask questions and were asked to sign a consent form before the interview began. For a copy of the consent form see Appendices (9-10). The interviews commenced with a series of questions to set the scene, followed by questions directed to the aims of the research. Participants were debriefed at the end of the interview. Interviews lasted between 20 and 95 minutes. Interviews were conducted with individual participants with the exception of one in which two parents of the same child were interviewed. After each interview was completed the researcher made a journal entry, providing essential reflection of impressions (see Figure 1 for an example).

16th October – Reflections on interview one - Danni

I had been keen to offer participants the choice as to where they wanted to be interviewed. Danni (who had been discharged 6 months previously) had opted to be interviewed in the service rather than at home. When I met her there I became aware it was her first visit back to the unit since her discharge. En route to the interview room we bumped into a member of staff who was clearly surprised to see Danni and hugged her. I wondered if this, or being back in the unit where the ward rounds had taken place would impact on the interview.

Figure 1: Extract from Reflective Journal.

2.4.10 Interview Guide

A semi-structured, flexible interview guide was developed after the researcher had conducted a preliminary appraisal of relevant literature. However, this remained open for participants to generate their own themes in order to ground the research in the data. An evolving interview schedule is in accordance with the theoretical sampling aspect of GT (see Appendices 11-12 for initial and final interview guides). Questions included a focus on:

- **Background:** Length of contact with service; number of WRs attended, status of residency (current resident/parent or former resident/parent)
- **Experiences:** Of WRs in general, different kinds of WR experience, atmosphere of WRs, impact of attending WRs.
- **Stability:** If views remained the same or changed at any point (a particular focus of views in interviews resulting from theoretical sampling).

2.4.11 Theoretical Sampling

Theoretical sampling involves using emerging data actively to seek out new cases, people, events or information to define the boundaries and relevance of the codes and categories elicited to date (Charmaz, 2006). In the current study the first interview was line-by-line coded before the second interview took place, and this process continued as the data collection progressed. At a later point in the data collection process the importance of seeking the views of current residents and young male service users was highlighted. Through the process of coding, constant comparison and memo writing, the researcher used theoretical sampling to adapt her later interviews to follow up emergent themes in the data and reflect a particular group of interviewees.

2.4.12 Data Analysis

Initial Coding / Line by line coding

In the current study this comprised the first level of transcript analysis, and the process was undertaken to represent chunks of meaningful data ranging from short phrases to paragraphs in the text. In accordance with the approach suggested by Charmaz (2006) the researcher remained open, stayed close to the data, constructed short, simple and precise codes and moved quickly through the data. For an example of a page of transcript that has been line by line coded see Appendix 13.

Concepts labelled during initial coding were used to capture 'active' psychological process in participants' accounts. The identification of actions or processes is more likely to facilitate the interplay between participants' accounts (Charmaz, 1995; 2006). As the analysis proceeded more concepts emerged and the researcher grouped together similar

concepts assessing which of these made most sense of the phenomenon of experiencing ward rounds.

Focused Coding

Focused coding formed the second level of transcript analysis and enabled the researcher to use the most significant and/or frequent codes to sift through the collected data (Charmaz, 2006). Focused coding was conducted on all nine transcripts with suggested codes written in the right hand margin. For an example of both line by line and focused coding see Figure

Line by Line Codes	<i>Extract</i>	<i>Focused Codes</i>
<ul style="list-style-type: none"> - purpose of ward rounds to talk about residents - real versus actual choice - needing to be there if talked about and decision being made - feeling had to attend ward rounds - choice offered not feeling a real one - not feeling like there was a choice 	<p><i>"I mean they didn't come each time and drag to ward rounds. I guess I went of my own accord, kind of. But I felt I had to for my own sake, I just felt, it was a choice but I didn't think the not gong option was possible for me, so not a real choice".</i></p> <p style="text-align: right;"><i>Joanna (lines 39-42)</i></p>	<p>FORCED CHOICE</p>

Figure 2: Example of Line by Line and Focused Coding with Excerpt from Transcript.

Memo Writing

During data collection and analysis, memo-writing was a useful tool for the researcher to track her thoughts. Memo-writing was used as part of the constant comparative method and helped direct further analysis based on previous data collection. By noting down possible codes and themes, the researcher was able to track relationships between them. Memo-writing can be seen as an intermediate stage between focused coding and the first draft of the final analysis (Charmaz, 2006). An example of a memo can be seen in Figure 3.

22/12/07- Forced Choice -

Forced choice seems to refer to a number of issues for Joanna, being talked about behind her back and needing to be present at an event where decisions were going to be made about her. For Meg this appeared to relate more to concerns about how the staff would perceive her absence and the need to be there to gain information. This is demonstrated in the accounts of Meg and Joanna below.

Meg: *"Anyone that truly cared about their child must surely have felt they have to go to the ward round. Not going was simply not an option for us and besides what would the staff think about absent parents"*
(Line 80)

Joanna: *"the real choice I had was whether I wanted them to talk about me in front of me or behind my back, that was frustrating and made me angry. I felt I had to be there if they were going to talk about me and make decisions about me, I can't say there wasn't a choice, there was, just didn't feel like a realistic one I guess".(Line 33)*

Relates to: Adaptation – as attending feels less like a "forced choice" when having attended more ward rounds and the process of Adaptation begins..

Figure 3: Example of a Memo

Raising Focused Codes to Theoretical Codes

Theoretical coding is described as a sophisticated level of coding that specifies possible relationships between categories developed in the prior stages of focused coding (Charmaz, 2006). This involved the further development of memos that defined the categories, describing the properties within them, identifying the conditions under which the category emerged and appeared to be maintained and the consequences of the category. The process of analysis continued until the author felt that theoretical 'saturation' had been achieved. This refers to the point at which gathering more data about a theoretical category reveals no new information or properties of any further insights into the emerging theory.

2.5 Methodological Rigour

2.5.1 Constant Comparative Method

The constant comparative method is a process of analysis that compares one set of interview data with another aiming to generate more abstract concepts, codes and theories (Charmaz, 2006). In the current study this included revisiting earlier transcripts to examine if codes

and categories emerging later on in the analysis had been evident in earlier accounts but had been overlooked or their significance not fully appreciated.

2.5.2 Peer Review

The researcher attended a qualitative support group during data collection and analysis. This enabled her to have other researcher's code her transcripts and discuss the emerging model with her peers and a facilitator familiar with qualitative methodology. This process was continued in weekly meetings with a member of the group, a 'peer debriefer' and regular sessions of research supervision with a qualified clinical psychologist experienced in the use of GT.

2.5.3 Reflexivity

Within GT the researcher is arguably in a position in which they are more a participant than an observer in the research process (Potter, 1996). This is discussed briefly in the next section and expanded upon in the Critical Appraisal section of the thesis. To make this process transparent a comprehensive audit trail was completed including the use of the field diary, reflective journal and the writing of memos.

2.6 The Role of the Researcher

2.6.1 Researcher's Stance

The researcher felt aligned with a social constructionist epistemological stance. This stance assumes that categories are not discovered within the data, but rather that they are constructed between the researcher and participants during the research process. Within the current study the researcher gained a sense that many participants were considering some aspects of their experience for the first time during their interview, with their accounts

appearing to emerge from co-constructions between researcher and participant. The social constructionist version of GT, as advocated by Charmaz (1990, 1995, 2006), was adopted as the researcher found this an accessible method which provided an appropriate framework for addressing the diversity of meanings attached to the experiences of attending WRs.

2.6.2 The Researcher's Assumptions

If researchers operate within a constructionist paradigm it is important that they are aware of or demonstrate a reflexive engagement with their own history, values and assumptions, as well as the relationship with participants (King, 1996). The research was conducted during my final year of training to be a clinical psychologist. I had no previous research experience using GT. My own clinical and professional experiences during clinical training had some impact on the choice of topic area as I had attended WRs as part of some of my clinical placements. I had found them varied and interesting experiences from a professional perspective. This led me to wonder what the WR experience would be for SUs and their carers who attended them. Within the context of clinical work, my particular interests lie in personal construct theory (Kelly, 1955) and the application of this theory to clinical practice and problems.

CHAPTER 3: ANALYSIS

3.1 Overview of Chapter

This chapter provides an account of the analysis of the nine interview transcripts taken from interviews with ten participants. A model made up of one core category and five main categories (themselves consisting of intermediate and lower-level categories) was generated from an analysis of the data. This model represents one way of understanding how young people and their parents experience WRs. Although two family dyads existed within the sample of participants the aim of the analysis is not to make comparisons between members of the same family but to explore individual accounts of experience.

The chapter begins with a brief definition of the different levels of the process model and how they relate to each other. Representing the model in this way ensures that the story has conceptual depth and is grounded in participants' accounts. An overview of the core category and an outline of the five main categories pertaining to the core category are described. Within four of the main categories is an outcome category, which represents the process the intermediate categories appeared to result in for participants. For example, 'Seeking Understanding' typically resulted in an outcome of 'Feeling Supported'. At each stage of the model, direct quotes from the interview transcripts are used to explicate the categories. These are presented as indented paragraphs in ***bold italicised*** text and each quote includes the participant's pseudonym and the line number to show its location in the transcript. Due to word count constraints, additional supporting quotes can be found in Appendix 14.

3.2 Defining the Model

The core category in this model represents an attempt to conceptualise the ‘story’ contained within each transcript when read as a whole (Charmaz, 2006). The main categories represent the key components of the story pertaining to the core category. The intermediate-level and lower-level categories constitute further explication of the main categories. The model is demonstrated in Figure 4.

3.3 Overview of Core Category

The core category generated from the analysis is termed ‘Adaptation’. This was the focus of the storyline and was comprised of five main categories. These were: ‘Anticipating’; ‘Seeking Understanding’; ‘Managing Immediate Impact’; ‘Readjusting Expectations’; and ‘Further Consolidation of Experiences’. These five main categories are outlined below. The core category represents the process by which SUs and their parents “adapt” to attending WRs and to both the process and content associated with this event.

‘Adaptation’ was the core category as this appeared to represent how participants became more used to attending WR over time and the coping strategies they adopted in order to deal with the more difficult times both during and in between WRs. Although adaptation may appear to be an ‘end point process’, in this instance it is more of a circular process with the various stages within the main categories ensuring that the process of adaptation can take place.

‘Adaptation’ appeared to be a process involving both aspects that relate to events occurring during the WR and to the wider impact attending WRs has and continued to have as more

WRs were attended. The core category of adaptation is aptly demonstrated in the words of Dougie below:

“There are so many different things about ward rounds that you have to get used to. Even before you go to one, and then when you first go, that’s a big thing to adjust to. But it doesn’t even end there, you have to continue to adapt to going week after week, and the different things that happen there. When you stop going, you have to adapt to that too. I have been discharged for a month now and maybe only now do I fully understand what the process of going them was like”

Dougie, young person, Line 302

In his closing remarks in the interview he adds:

“And you know, the ward round wasn’t going to change really, so I guess I needed to not change but adapt to the ward rounds, what is it they say ‘When in Rome’...”

Dougie, young person, Line 324

The process model depicted in Figure 4, illustrates the interaction between the main categories. Using participants’ accounts, the relationship between these categories was formulated as a cyclical process model.

The first main category represents participants’ ‘Anticipating’ the WR both in relation to their first WR and subsequent attendance. The arrow indicates that this process leads to the second main category is termed ‘Managing Immediate Impact’. This is the process that

participants went through to feel able to cope with and manage the impact that attending WR had. Although this category appeared to happen before the third main category, 'Seeking Understanding', there appears to be a reciprocal relationship between the two, hence the double headed arrow. 'Seeking Understanding' represents a phase of using the WR as an avenue to seek understanding about the rounds themselves but also about wider issues relating to admission and recovery. 'Managing Immediate Impact' and 'Seeking Understanding' both have a relationship with the core category of 'Adaptation' as the processes occurring within these categories required the need for some form of adaptation. These two categories appeared to relate to the fourth main category, 'Readjusting Expectations'. This category also feeds in to the process of 'Adaptation' and these readjusted expectations, are used to inform a new process of 'Anticipation', this time based on actual experiences, the arrow at this point demonstrates how this leads to a fresh cycle of the process model. Finally, for participants who have been discharged, a process of 'Further Consolidation of Experiences' appeared to occur, despite them no longer attending WRs.

THE PROCESS MODEL

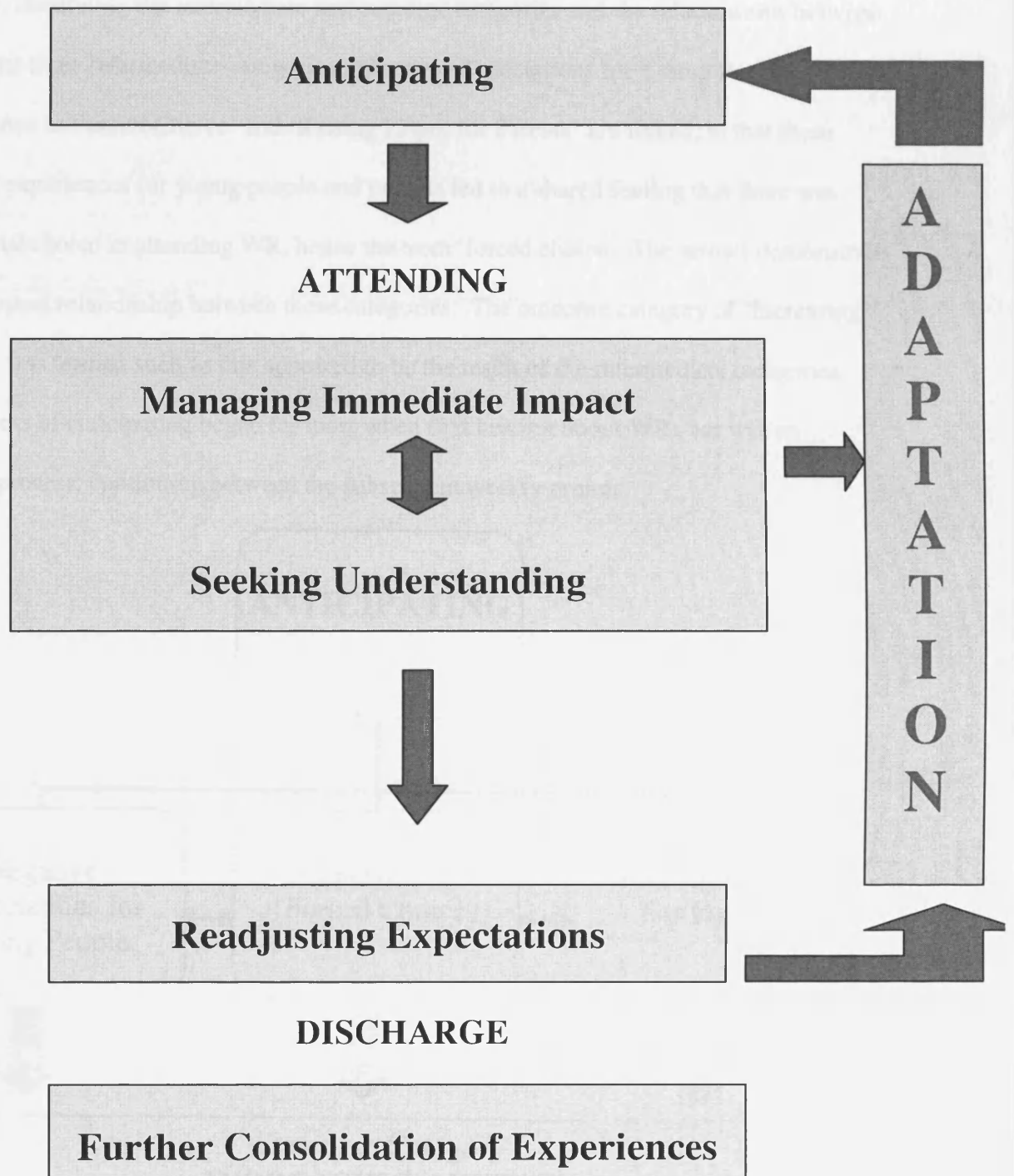


Figure 4. The Core Category of Adaptation within the Process Model

3.4 Main Category 1: ANTICIPATING

The first main category of experience was termed 'Anticipating'. Figure 5 depicts this category, illustrating the intermediate and outcome categories and the relationships between them. The three intermediate categories, 'Negative Expectations for Young People', 'Attendance as Forced Choice' and 'Raising Hopes for Parents' are linked, in that these different experiences for young people and parents led to a shared feeling that there was little actual choice in attending WR, hence the term 'forced choice'. The arrows demonstrate the reciprocal relationship between these categories. The outcome category of 'Increasing Anxiety' was termed such as this appeared to be the result of the intermediate categories. The process of anticipating began for most when first hearing about WRs but was an ongoing process, continuing between the subsequent weekly rounds.

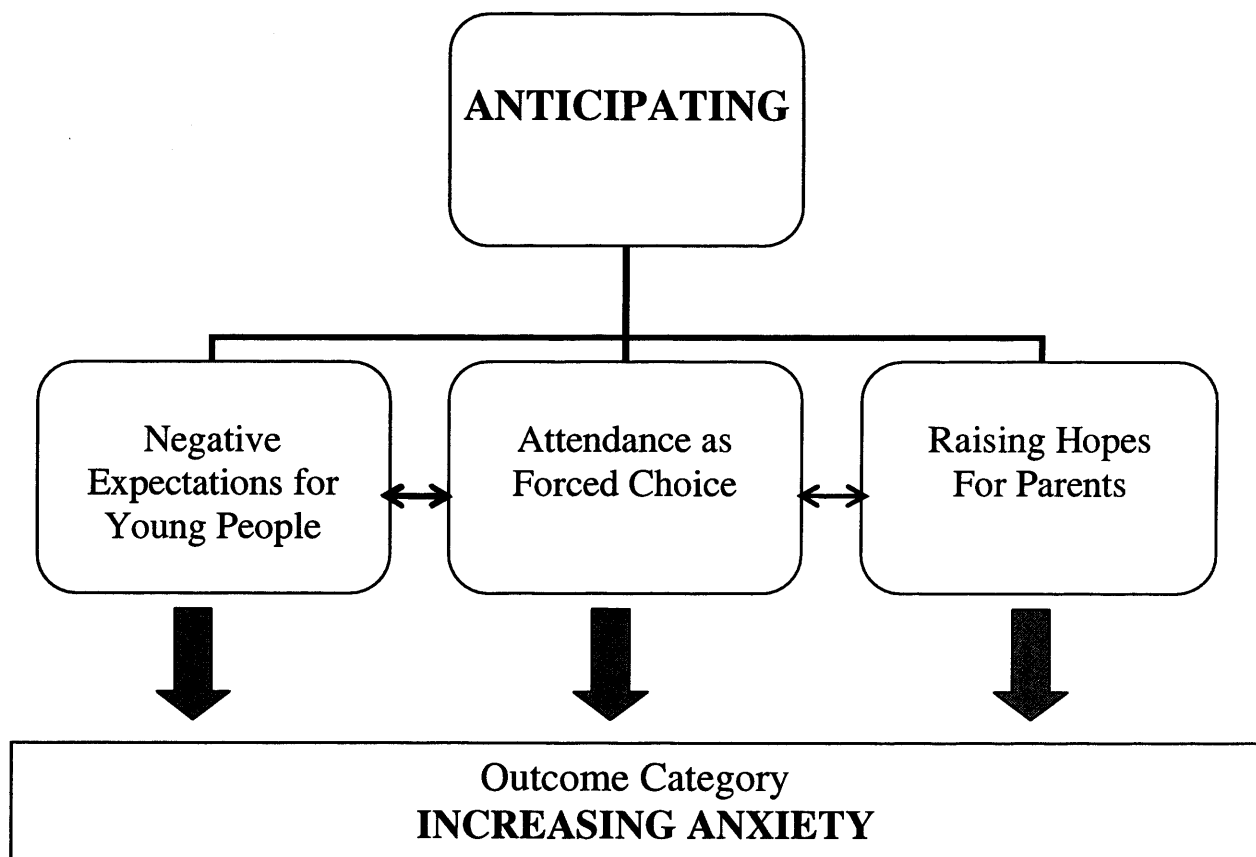


Figure 5: Main Category 1 – Anticipating

3.4.1 Intermediate Category: Negative Expectations for Young People

The anticipatory process was found to mainly take a different form for young people compared to parents. For young people when they first heard about WRs most of them experienced a negative reaction. For Jordan, as can be seen in the quote below, the anticipation related to a fear of the unknown which evoked strong emotions such as anxiety, confusion and fear. It is also worth considering the context in which this anticipation was taking place for young people, which was within the inpatient unit itself (unlike parents who would typically engage in this process outside the unit).

“Before I went to the first ward round, I just remember feeling very confused and anxious about them. When I thought about them, they felt like they were going to be one more hoop to jump through, and having no knowledge about what to expect just didn’t help at all. So I thought about them a lot before I set foot in one, building them up to be something to be scared of.”

Jordan, young person, Line 47

A further form of anticipation related to the young people who had been given information about the WR but still went through a process of contemplating what attendance would be like.

“Oh yeah the staff told me what to expect to some extent, like who would be there. But I just thought it won’t be as positive as they are making it out to be. I thought, before I went, it would not be a nice experience and it wasn’t but the staff only tell you about the positives and leave you to wonder about the rest, which I did”

Dougie, young person, Line 44

3.4.2 Intermediate Category: Attendance as Forced Choice

Attendance at WR is optional; staff in the service described encouraging SUs to attend but also explain that it is not compulsory. For most participants, the choice of whether to attend or not was felt to be a complicated decision. A key issue was the knowledge that the WR would take place with or without them present. The fear of being talked about in their absence appeared to prompt many participants to attend whether they wanted to or not. Many participants referred to this as feeling like it was not a realistic choice. Joanna speaks of the frustration and anger associated with this decision:

“The ward rounds happen whether you are there are not, your ward round, About you, happens. So the real choice I had was whether I wanted them to talk about me in front of me or behind my back, that was frustrating and made me angry. I felt I had to be there if they were going to talk about me and make decisions about me, I can’t say there wasn’t a choice, there was, just didn’t feel like a realistic one I guess”.

Joanna, young person, Line 32

There were some commonalities in this category between young people and their parents, in that neither felt they wanted to be talked about in their absence. For young people this emerged from a sense of wanting to defend themselves in WR discussions. For parents, this related more to a fear of being judged and needing to be there to hear what was said first hand. Parents also felt attendance was a ‘forced choice’ as they saw WRs as the main avenue from which to gain information from those involved with their child’s care. Furthermore for parents there was a concern that non-attendance may lead staff to believe they do not care about their child. Meg speaks of this below:

“Anyone that truly cared about their child must surely feel they have to go to the ward round. Not going was simply not an option for us, even though in reality we would both have preferred not to be there and to get the information elsewhere. Had we not gone staff may have thought we just didn’t care and judged us accordingly”.

Meg, parent, Line 80

Whilst the majority of participants describe ‘forced choice’ in their accounts one participant provided an exception to this. Jordan attended the first WR and then made the decision not to attend further ones. As the following quote illustrates she thus did not see attendance, but non-attendance as a forced choice.

“They sounded so overwhelming. I went to the first one, yeah, which is how I know what they were like, but I found them, the ward rounds too much. I had been encouraged to go and I felt I should go, but I had to decide what was best for me and at the beginning not going was best”

Jordan, young person, Line 8

Although the course of action Jordan took differed to other participants in that she felt the best way forward for her was to not attend that WR, it is still clear from her account that she also viewed attendance as a forced choice. Referring to the feeling she should attend supports this and demonstrates that this category name is still applicable, even when faced with a negative case.

3.4.3 Intermediate Category: Raising Hopes for Parents

The process of anticipating typically took a different form for parents. For them, the knowledge of having to attend WRs appeared to engender a more positive form of anticipation. They felt it an opportunity to have contact with those involved in their child's care, which made them hopeful, as can be seen in the quote from Suzie:

*“When I first heard I would have to attend a ward round I was relieved.
Well I was glad I was going to be involved in my daughter's care.
It went from me being quite worried we would not be involved to being
hopeful that we could be party to the decisions that were made and that
we could get answers to our questions. I still got anxious before every one
though!”*

Suzie, parent, Line 14

Similarly for Ben, another parent, the chance to attend WRs made him feel optimistic as he saw this as a chance to be involved in the decision making process.

*“When we were told what structure the ward round would take, in that we
could ask questions and have some input into the decisions, we felt optimistic.
Just seeing so many people there involved in our daughter's care, gave us hope.
We found that reassuring so in a strange way we would look forward to them”*

Ben, parent, Line 26

One exception to this was a parent who did not engage in any form of anticipation for reasons that can be seen in the quote below. This participant worked in the health care

profession and had knowledge of the psychiatric system. Although he had never attended a WR in a professional capacity he clearly had an awareness of what they involved.

“I know what ward rounds are; I have professional knowledge of them so I didn’t really think about it much at all other than, right I need to turn up this day at this time”

Charlie, parent, Line 34

3.4.4 Outcome Category: Increasing Anxiety

A number of participants commented that information given in advance had not fully prepared them for the WR experience. Both receiving explanations and a lack of explanation were seen to relate to an increase in anxiety for many participants. This was more evident for young people than parents as can be seen in the words of Tom below.

“I think, they mentioned it on the induction day. But just in passing like. I didn’t really know what one was to be fair, not knowing got me quite anxious about what would happen, I just got more worried really I guess”.

Tom, young person, Line 23

3.5 Main Category 2: MANAGING IMMEDIATE IMPACT

The second main category referred to the process by which participants attempted to manage the immediate impact of the WR. This refers mainly to the initial impact of attending but also to significant events they encountered at other points during attendance. Intermediate categories within this were: ‘Feeling Under the Spotlight’, ‘Active Avoidance’, ‘Intensifying Emotions’ and ‘Feeling Judged’. In order to manage the impact of these categories two

outcome categories appeared to occur, 'Becoming Part of the Routine' and 'Adapting Behaviour'.

The main category is depicted in Figure 6 and is a flat hierarchy consisting of only intermediate categories as all appeared to be of equal importance in participants' accounts. Two intermediate categories ('Active Avoidance' and 'Intensifying Emotions') were linked to each other. It appears that despite many participants' best efforts to actively avoid reflecting during the week, WRs often forced realisation and reflection. As this was a difficult process it was said to intensify emotions, hence the reciprocal arrow between the two.

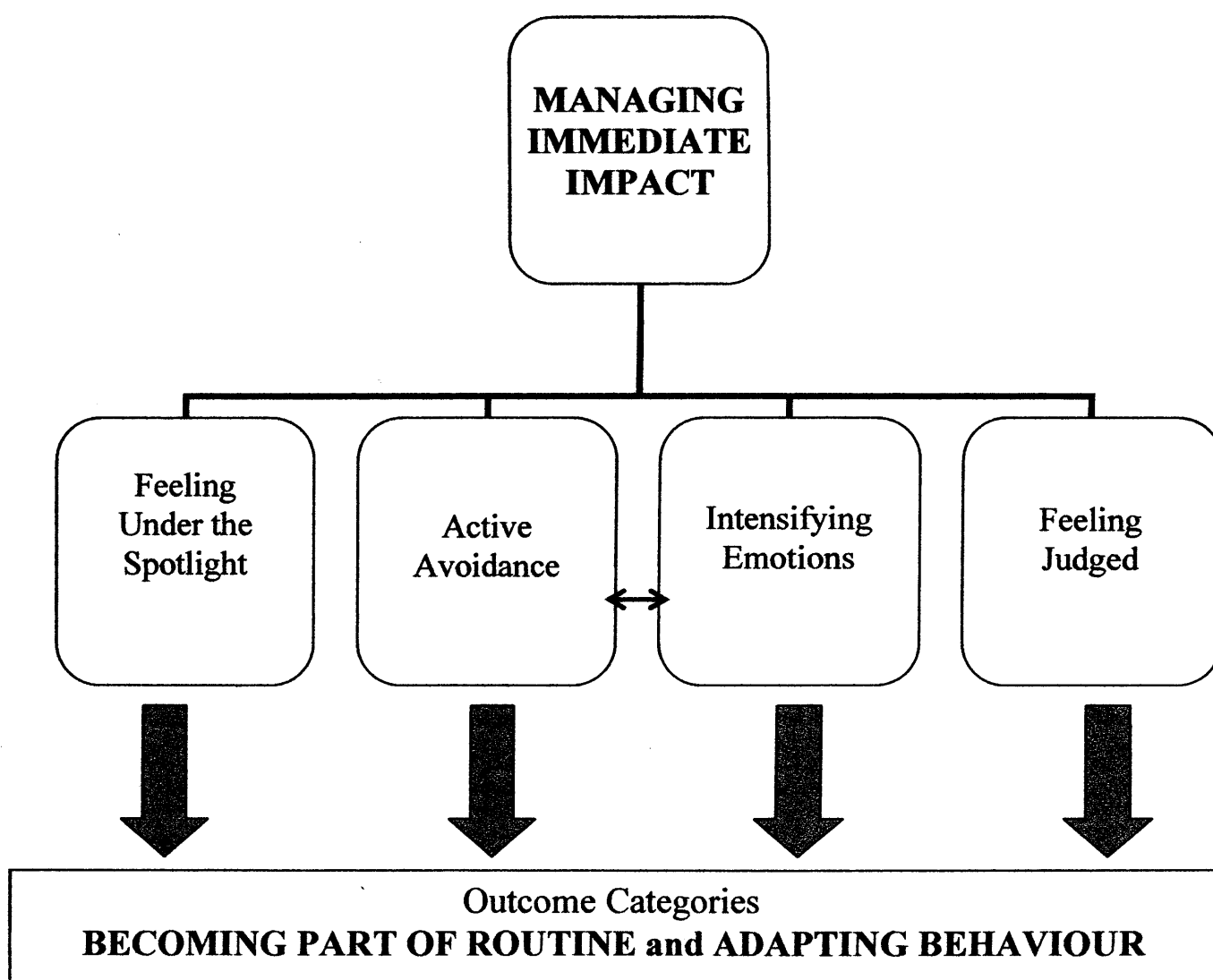


Figure 6. Main Category 2- Managing Immediate Impact

3.5.1 Intermediate Category: Feeling Under the Spotlight

This category related to participants feeling on show at WR in front of what was often high numbers of staff. Although this appeared to be more of a negative issue for young people, it was also an important factor for some parents too. For young people feeling under the spotlight was not seen as a positive factor as can be seen in the following quote from Joanna:

“I feel watched and I feel uncomfortable. Mainly at ward rounds but not just then. In the week too. In the week though you’re never watched by about ten people at the same time! It would have been easier with fewer people there I think. All those people, scrutinising me at ward rounds was not nice”

Joanna, young person, Line 152

Some parents were able to cope with this by reminding themselves that all the staff present were involved in their child’s care which helped reassure them. Harry found being under the spotlight difficult but coped by being aware of the positive aspects of this:

“There was a lot of people in there, about ten, maybe more. You are sat at the front, next to each other, we were in a row of three. It felt like we were on stage. The staff were in a U-shape around us, looking at us – hard not to feel watched like that but I coped knowing that meant there were lots of people to help our family”

Harry, parent, Line 29

3.5.2 Intermediate Category: Active Avoidance

For young people and parents the WR appeared to be an environment which forced self-reflection. During the week most participants attempted to cope with difficulties regarding WR by choosing not to think about them. For most participants this was described in a negative manner as can be seen in Joanna's quote:

"I can avoid how I feel about some things in the week and how I feel about myself. I think it [ward round] just forces you to think about the past and what has gone wrong and I find that hard, especially with my parents there!"

Joanna, young person Line 132

For parents the issues they often tried to avoid considering related to how their child had "ended up" in inpatient care and the future prospects for the family unit. This is demonstrated in the following quote from Suzie:

"To some extent in the week you can forget about the fact you have a child who is in a mental health unit. It can be put to the back of your mind, you can escape. Come ward round day and you simply have to think about it – it forces you to, want to or not. And I would sit there and think how the hell did things turn out like this, what went wrong?"

Suzie, parent, Line 102

For Charlie the reflection was a positive experience, even in the early stages of his child's inpatient stay. He used the WRs to reflect on the progress that had been made. Realisation for this participant was said to have occurred at the point of admission.

“I didn’t need a ward round to make things hit home for me, having her [daughter] admitted to the unit did that, though I saw it coming anyway. But they were useful to reflect on the progress that was made from week to week, it was all about reflection really, couldn’t avoid it”

Charlie, parent, Line 102

This was a unique experience as this was not reflected in any other participant’s account.

3.5.3 Intermediate Category: Intensifying Emotions

Most young people and parents referred to the context of the WR as being one in which their emotions were intensified. For some this was a result of the previous category in which it appeared that the WRs often forced participants out of an avoidant state and into realisation and reflection about their current experiences. Participants also referred to the WRs as intensifying the way they were feeling before they went in, where it appeared to magnify both positive and negative moods. Danni refers to this below:

“Some days I would just feel crap about myself, about being in the unit, about how the week had gone, I would feel depressed and anxious and like I was no good and when the weeks events were dragged up at ward round it just made me feel even worse. If I went in feeling 8 out of 10 bad I would usually leave feeling 10 out of ten bad and a mixture of sad and angry”

Danni, young person, Line 79

Similarly both the WR and having a child in inpatient care was a difficult experience for many parents as can be seen in the emotive words of Meg:

“To be honest after the first one, I left feeling so drained, so awful, worse than when I went in. I was upset and anxious, and mad, and it got worse.

Meg, parent, Line 45

3.5.4 Intermediate Category: Feeling Judged

Young people’s accounts demonstrated that under certain circumstances they would feel judged during WRs. This was especially the case when events that had occurred during the week were raised at WR in front of their parents which appeared to generate strong emotions. A number of participants’ accounts demonstrated that they felt they had to live through difficult situations twice, when they occurred during the week and then when it was raised again at WR.

“One thing I did hate about the ward round, it made me so mad, was how they brought up all the crap that had happened during the week, even if it had been dealt with at the time. It was like the staff were wagging their fingers at me in front my Mum saying naughty, naughty”

Danni, young person, Line 86

Feeling judged during ward rounds was also an issue for parents, though this did not appear to arise from anything that the staff did or said. It appeared more of an internal fear which was attributed to the predicted views others would hold of parents who had a child in a mental health unit. This is demonstrated in the following quote from Suzie:

“There is something about the ward round environment that made me feel judged. When your daughter has been admitted to an inpatient mental health unit, it’s hard to think they won’t judge you. I thought, they think we have failed and are judging us. Maybe we felt we had failed her, and were judging ourselves”

Suzie, parent, Line 167

3.5.5 Outcome Level Category: Becoming Part of Routine

This category reflected how for many participants the weekly occurrence of WRs resulted in it starting to feel part of a routine. For young people the fact that WRs happened on the same day, at approximately the same time resulted in it being one of the first forms of adaptation taking place.

“The ward rounds happen like clockwork, well they happen the same day, each week at about the same time. After you get over the initial newness of them and get the first few out of the way you just adapt to then. You think oh its Wednesday, its ward round, it becomes part of the routine, like getting out of bed, you don’t even think about it anymore”.

Jordan, Young Person, Line 195

For parents who wanted to attend WRs every week there were practical matters to consider in order that attendance was possible, most commonly needing to take time away from work which Ben speaks of below:

“You have to adapt to needing to attend every week. It’s good work understands, I have to take Wednesday mornings off every week this means I have to work longer hours the rest of the week. And of course after a while going there instead of work on a Wednesday now it just feels routine, it is Wednesday now that doesn’t mean work it means ward rounds”

Ben, parent, Line 48

3.5.6 Outcome Category: Adapting Behaviour

‘Adapting Behaviour’ fitted within ‘Managing Immediate Impact’ as it was a way in which participants, in particular young people attempted to make WRs as easy a process as possible. For a number of young people after attending a number of WRs they came to the realisation that there could be positive benefits of adapting their behaviour during the week. This is demonstrated in the words of Tom below:

“I just wanted an easy life at ward round and I knew if I messed about in the week it would get brought up and make it a difficult time so I changed how I behaved in the week to make it easier for me and my folks.”

Tom, young person, Line 141

Charlie, a parent, gave a different example of adapting behaviour at WR in order to make them have less of an impact on his daughter:

“I made the mistake at the first WR of taking the lead, but it made my daughter mad. She said I took over and that had a big impact on her. So I made a point to change at the next one and let her lead and ask me to contribute as and when.”

Charlie, parent, Line 66

3.6 Main Category 3: SEEKING UNDERSTANDING

The third main category was termed ‘Seeking Understanding’ and referred to the process by which participants attempted to gain understanding from the WR. The first intermediate category was ‘Importance of Shared Understanding’. This was a particular issue for young

people whose accounts reflected the belief that only other inpatients could fully understand their WR experience. 'Seeking Information' referred to mainly an initial process undergone especially by parents, which included factors relating to treatment programmes, medication and length of inpatient stay. Relevant to both young people and parents was the intermediate category of 'Wanting to Feel Heard'. This referred to participants wanting their contributions at WRs to be taken on board by staff members, leading to frustration and upset when this did not happen. The outcome category was termed 'Feeling Supported' which was the process resulting from the three intermediate categories. This main category can be seen in Figure 7 below.

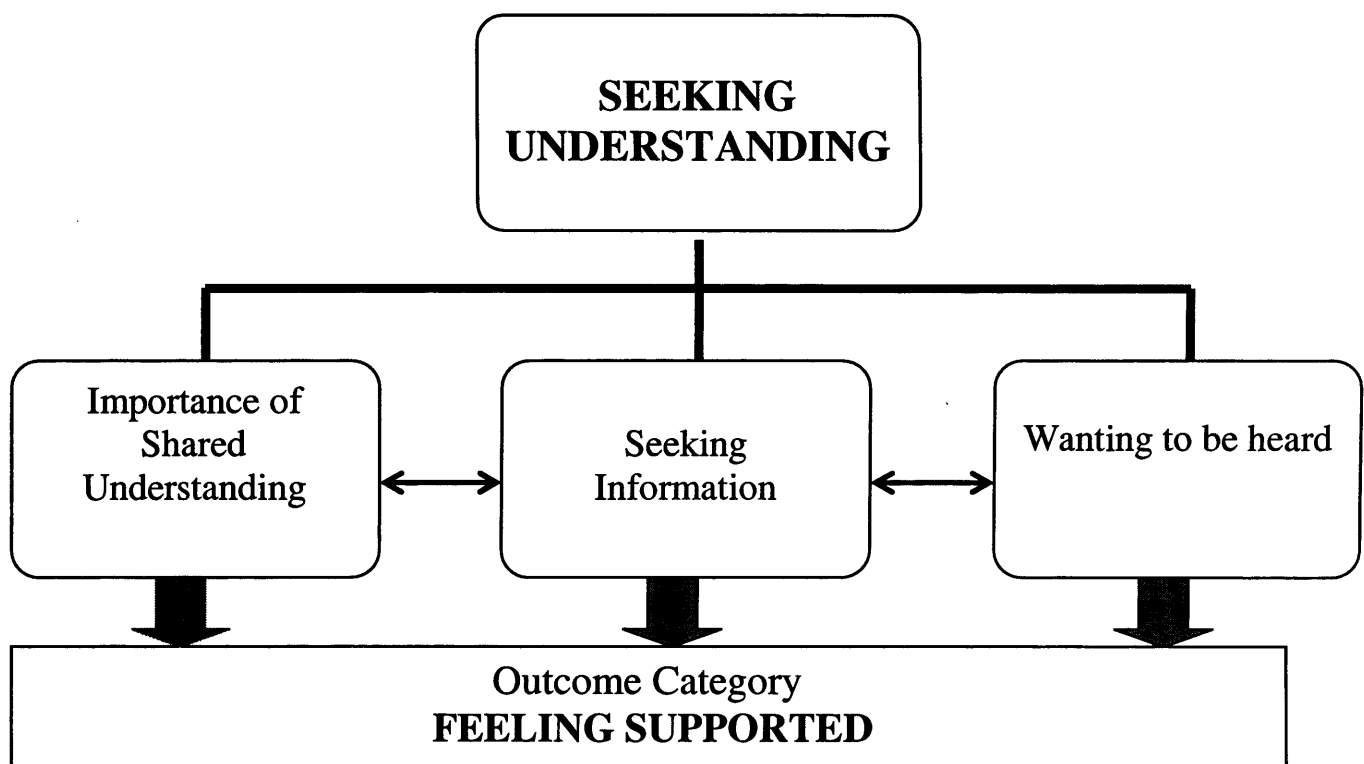


Figure 7: Main Category 3 – Seeking Understanding

3.6.1 Intermediate Category: Importance of Shared Understanding

Young people especially held strong views about who could fully understand what the WR experience was like for them. This included the view that their experiences at WRs as ‘patients’ was unique, as they are the ones being spoken about. Danni’s account shows how she was considering this for the first time within the interview and how the shared understanding she felt she had with the other inpatients determined who she would talk to about any difficult experiences encountered during WRs:

“I have not really thought that before. I know the other inpatients can understand what it feels like, no-one else can really. I think the ward round is such a different experience if you’re the patient, only they knew where I was coming from”

Danni, young person, Line 127

A similar process was evident in a number of parents’ accounts. They agreed with the young persons’ perspective of not being able to understand what experiences of WRs were like for their child. The similarities in debriefing with those perceived to have a shared understanding can be seen in Meg’s words below:

“It’s difficult; I would only really talk to my husband about how I felt about the ward rounds. I would not talk about it to our daughter; she would take it the wrong way, would think I was not allowed to struggle with them. The staff, unless they have had a child in inpatient care they would not understand, but my husband would”.

Meg, parent, Line 205

3.6.2 Intermediate Category: Seeking Information

As WRs were held weekly with most of the key personnel in the child's care present, it is perhaps not surprising that it was seen as an opportune time for parents and young people to seek information. For young people this appeared to serve more of a functional form, for example, making requests for leave. For parents it typically involved seeking information regarding their child's treatment and weekly progress. Danni, a young person, found it difficult at times to get her questions answered during the week. The fact that staff would be present at WR increased the hope she would obtain information at that point:

"I was able to get information that I may have struggled to get from staff in the week, so I would save up my questions until ward round, I knew the people who could answers my questions would be there and it saved me hunting them down in the unit in the week."

Danni, young person, Line 121

It was not unusual for participants to save up any questions and ask them at WR. As a parent Charlie appeared to have many questions which may have related to him working as a health care professional himself:

"The ward round was the one time in the week when all the people with the answers would be in the same room at the same time. For those that don't know about health care, like I do, this would be an ideal avenue to get information."

Charlie, parent, Line 121

3.6.3 Intermediate Category: Wanting to Feel Heard

Both young people and parents expressed a desire to feel heard and frustration when they felt they were not. Interestingly, this appeared to be a parallel process within the interviews where participants appeared to want to be heard by the researcher. For many, WRs provided a chance to raise issues of importance for participants and contributing was often found to be a difficult experience. Tom refers to not feeling heard and of being fearful to raise issues:

“I would get so annoyed if I raised something and it wasn’t taken notice of. When they ask for your opinion, and you give it, I mean, what’s the point of that. I had some things I wanted them to hear about how I felt but it just fell on deaf ears”

Tom, young person, Line 178

Although some parents also experienced the frustration of not feeling heard, for Charlie this was not the case. Whilst this might seem to contradict this category it is worth noting that this experience for Charlie was a result of his involvement in working in the health care profession. One can therefore assume that this intermediate category remains valid for participants experiencing the WR in a “non-health care professional” capacity:

“I never felt ignored or not heard really. They appeared to take what I said on board and I think I gave them useful advice too. It felt a two way thing and it should do really with the job I do”

Charlie, parent, Line 174

3.6.4 Outcome Level Category: Feeling Supported

The outcome category here was termed 'Feeling Supported' as this demonstrated the result for most participants of engaging in the other intermediate categories. For example, through the processes of debriefing with those with shared understanding and seeking information many participants felt they gained support. Joanna speaks of this below.

"I got so much support from the other inpatients. We would debrief after ward rounds. I felt I had a shoulder to cry on and that was an invaluable source of support. It came from their knowing what it was like to sit through the ward round as a patient."

Jordan, young person, Line 213

Support was also important for parents as was a shared perspective of the WR experience. Accounts demonstrated that many parents felt a general sense of support from staff but that their own spouse with knowledge of their family, was able to provide the support they needed. Ben refers to this below.

"We get through it together, the wife and I. She knows I struggle with ward rounds and we talk about it on the way home in the car. It really helps. She makes it all more bearable".

Ben, parent, Line 213

3.7 Main Category 4: READJUSTING EXPECTATIONS

The penultimate main category in the process model was termed 'Readjusting Expectations' and feeds back into the core category of 'Adaptation'. The intermediate category was termed 'Considering Reasons Behind Changed Views', with this appearing to be a process

most participants went through when considering how and why their views had changed. This had a reciprocal relationship, with the lower level categories of 'Recognising the Positives' and 'Living with the Negatives'. The outcome category, 'Developing New Expectations' demonstrated the way in which WR experiences informed the way in which participants readjusted their expectations. This appeared to be in order to adapt to the WR. These new expectations fed back into the model at the stage of 'Anticipating'. This main category can be seen below in Figure 8.

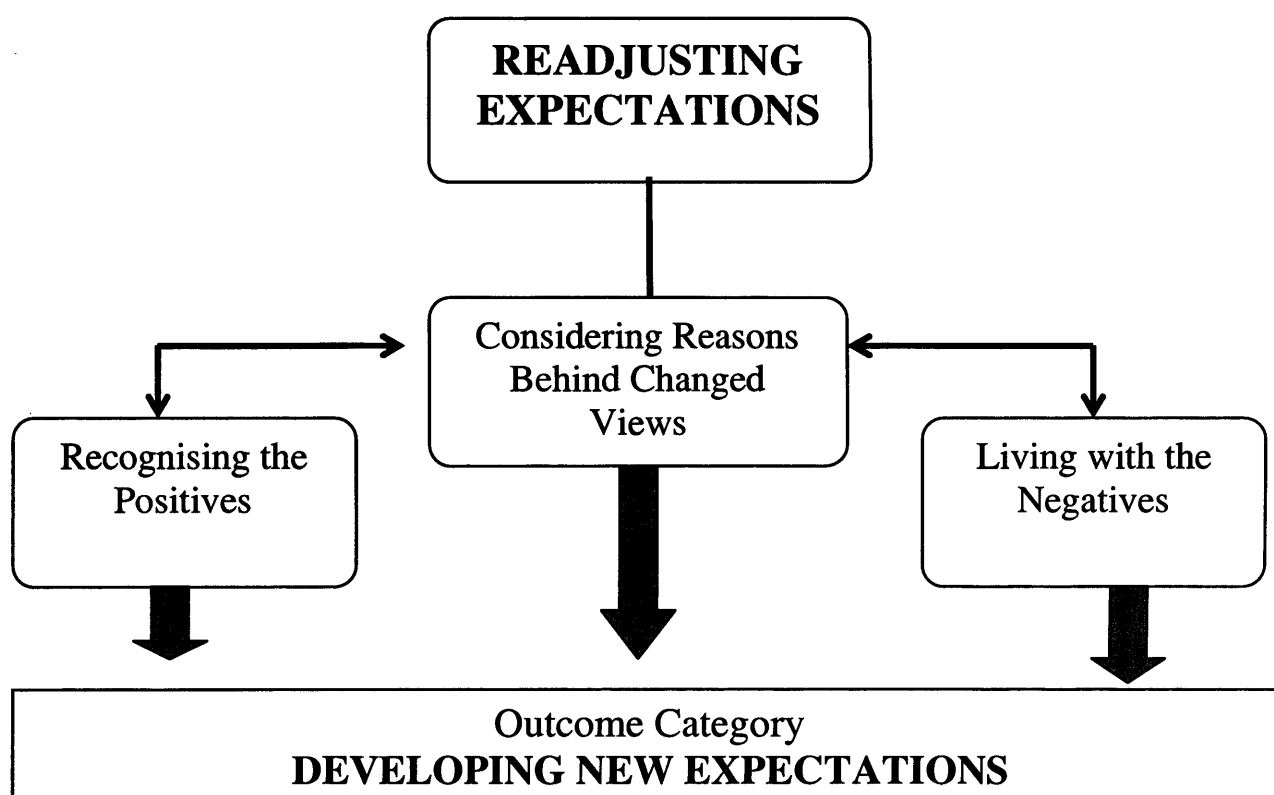


Figure 8: Main Category 4 – Readjusting Expectations

3.7.1 Intermediate Category: Considering Reasons Behind Changed Views

The first intermediate category referred to the process by which many participants considered the reasons that some of their views regarding WRs had changed. The interviews appeared to serve as a catalyst for this process, as many participants appeared to

be contemplating this for the first time during the interviews. This would be in line with the social constructionist form of Grounded Theory. This tended to occur when participants become aware that their views of the WR were starting to change, or already had. This led them to contemplate whether it was the WR itself that had changed or their views of them. Jordan speaks of this below:

“I thought at first I would always find the ward rounds hideous but my views started to change when I started to get better in myself, then they felt more bearable. I felt okay being there. I changed, not the ward rounds”

Jordan, young person, Line 17

Suzie attributed the reasons behind change more externally:

“I guess maybe my views have changed, seeing my daughter improve, support from my family I think they have helped really, and being away from the unit, those things combined maybe have led to a revised view. Nothing I have done. That’s all.”

Suzie, parent, Line 418

3.7.2 Intermediate Category: Recognising the Positives

A further experience typically occurring after participants had attended a number of WRs was ‘Recognising the Positives’. This appeared to be a process that occurred later on during the inpatient stay for young people and at an earlier point for parents. Dougie refers to this below:

“I don’t always see the positives, or what I have achieved, say in class.

Sometimes it takes ward rounds to make me see these things. When I felt

I had achieved something the ward rounds felt really positive. And I dare

say I achieved things at the beginning but I was too angry to see them.

***I used to hate my parents being there too but even that got to be a
positive thing”***

Dougie, young person, Line 164

For Harry, he was able to acknowledge that there had been a positive impact on him since attending the WR:

“The ward rounds certainly helped my confidence grow. Just having felt

I had got used to them made me feel I had achieved something. That was a

positive thing I took away from them”

Harry, parent, Line 305

3.7.3 Intermediate Category: Living with the Negatives

In a similar process, ‘Living with the Negatives’ typically happened over time. The issues that may have initially served as a source of annoyance or frustration for participants became more bearable, even if they were factors that remained difficult. This is referred to by Dougie below:

“Some aspects of the ward rounds sucked all the time. Like the ridiculously

high number of staff there, that didn’t change but I think you just get use to it, and

learn to live with it really – that and them feeling rushed, you just accept it’s not

great but its how it is and get on with it. That gets easier in time”

Dougie, young person, Line 282

Meg, a parent, was considering this for the first time in the interview, but had a similar account to that of Dougie, showing some commonality between young people and parents in this category:

“I haven’t thought about this til now really but you just kind of get used to the bad aspects of the rounds, no point trying to change things really so you learn to accept them, doesn’t mean you approve of them though”

Meg, parent, Line 263

3.7.4 Outcome Level Category: Developing New Expectations

The outcome category of ‘Developing New Expectations’ referred to the experience participants had of changing their initial expectations in light of the experience and understanding they had gained from attending WRs. This often came hand in hand with a reflection on initial expectations as demonstrated by Danni:

“I think initially my expectations were unrealistic through wanting too much. I just started to just expect the ward round to be a chance to get an update rather than to hear when the “cure” would happen, more realistic”

Danni, young person, Line 149

Suzie, a parent, shows a more external attribution to her developing new expectations:

“I think your expectations change with the course of treatment your child is having, I decided just to expect to be updated and kept informed. I gave up expecting to be told she would be released, I knew she wasn’t ready”

Suzie, parent, Line 402

3.8 Main Category 5: FURTHER CONSOLIDATION OF EXPERIENCES

The final main category was termed “Further Consolidation of Experiences”. This was a single component category that referred to participants following discharge, which describes the ongoing process of adaptation that took place outside the context of being either an inpatient or the parent of an inpatient. Jordan and Suzie talk of this process below:

“I expected to be discharged and just forget about the unit and the ward rounds. How wrong was I? In fact I think the most useful thinking about ward rounds for me was after discharge. It was almost like I needed to be free of the unit to fully think what my ward round experience was like and what the impact of going to them was. The space and distance helped me revise my views and reconsider my experiences”

Jordan, young person, Line 230

Suzie, a parent had a similar take on the importance of being able to reflect on the WR experience after her daughter had been discharged.

“I would not have been able to think about my experiences of ward rounds when I was still attending them, there was too much going off. It is like we needed to put them behind us, the whole inpatient thing behind us to think about them freely”

Suzie, parent, Line 346

3.9 Summary of Analysis

This chapter has outlined the various stages of the process model that seeks to explain how young people and their parents experience WRs in the context of an inpatient mental health unit. The core category of 'Adaptation' described the process which participants described going through to help them anticipate, understand, manage and cope with attending WRs.

In particular, the initial process of 'Anticipating' occurs before having attended the first WR but also in between subsequent rounds. The processes of 'Managing Immediate Impact' and 'Seeking Understanding' explain how participants try and cope with the impact of the WR, in particular relation to the first WR and subsequent events at WRs which they have found difficult. Finally the way in which participants adjust their expectations in light of WR experiences was described in 'Readjusting Expectations'. For participants who have been discharged, 'Further Consolidation of Experiences' refers to their consideration of WR experience that appeared to continue despite no longer attending.

It has been argued in this section that there are areas of both commonality and difference in experiences of WRs for young people and their parents. Interestingly, some of the intermediate category names may be equally applicable to both these groups but at different stages of their WR experience. For example, young people generally took longer than their parents to 'Recognise the Positives'. Similarly, some of the categories are applicable to both groups but may take a different form. This was seen in the first main category of 'Anticipating', where the process of thinking about WRs before attending resulted in 'Raising Hopes for Parents' and 'Negative Expectations for Young People'. However, both of these experiences then led to 'Increasing Anxiety'. It is also worth noting that the views of current residents and those who had been discharged were similar but appeared to be

occurring at different stages within the process model (as current residents had not been discharged and therefore not reached the final stage of the process). Some current residents had however gone through the process as far as readjusting expectations, leading into adaptation and further anticipation based on the WRs they actually had attended.

CHAPTER: 4. DISCUSSION

4.1 Overview of Chapter

The previous chapter stated the main findings from the research. This chapter will aim to interpret these findings with reference to the research questions, previous literature and relevant theory. An interpretation of the analysis will be provided by reviewing the model constructed from the participants' accounts of their experiences of WRs. The implications of the findings with regard to theory and clinical practice will be considered, followed by a discussion of the limitations of the current study and suggestions for future research.

4.2 The Core Category of Adaptation

'Adaptation' refers to the way in which participants adjust to attending WRs, to their experiences of both process and content of WRs and the consequent impact WRs have. This was defined as the core category as it appeared to permeate all participants' accounts and to interact with the main categories. For most participants this occurred after initial attendance at WRs and continued with subsequent attendance and beyond discharge as a process of reflection and consolidation takes place.

The core category of 'Adaptation' has some parallels with concepts from developmental psychology such as schema formation and the processes of assimilation and accommodation (Inhelder & Piaget, 1958). Assimilation refers to the process of social adjustment designed to maintain harmony within a group, with the adjustment taking one of several forms including compromise, conciliation, arbitration, or the mutual acceptance of a truce. Accommodation, in Piageteian terms refers to the modification of internal schemes to fit a changing cognizance of reality (Inhelder & Piaget, 1958). Attendance at WRs possibly

challenges the existing schema for understanding the world as such experiences are initially novel. As more information about the new environment is gathered from increased attendance at WRs and integrated into existing schema, new schemas can be developed to make WRs more bearable.

It may also be useful to consider the Self Regulation Model which proposes that people construct cognitive representations of an illness in order to understand and cope with it (Leventhal, Nerenze & Steele, 1984). These cognitive representations are seen to determine emotional responses and to guide coping responses (Hunter, Grunfeld & Ramirez, 2003). It is possible that this may be a process engaged in for SUs attending WRs but as it was only alluded to by a couple of participants in this study any conclusions remain tentative.

4.3 The Process Model

The process model was constructed from participants' accounts of their WR experiences and was described in the analysis chapter of this report. In order to understand why participants engaged in the processes of 'Anticipating', 'Managing Immediate Impact', 'Seeking Understanding', 'Readjusting Expectations' and 'Further Consolidation of Experiences'; it may prove useful to consult the Experience Cycle in Personal Construct Psychology (Kelly, 1955).

Kelly refers to the Experience Cycle as the essence of all construing (Kelly, 1970). In its first stage, *Anticipation*, a prediction is formulated regarding a particular event. In the current research the event would be the WR and the predictions can be seen in the intermediate categories of 'Raising Hopes for Parents' and 'Negative Expectations for Young People'. Similarities also exist between the *Encounter* phase of the Experience Cycle

where an open and active experiencing of the event takes place as seen in WR attendance in the current research. Similarly, the *Constructive Revision* phase is resonant with this study's category 'Readjusting Expectations'. In both, the person engages in any reconstruing which is deemed necessary following evaluation of evidence obtained during the encounter. This sets the stage for a fresh anticipation and a further experience cycle to begin.

4.4 Main Category 1: Anticipating

The first main category of 'Anticipating' comprised the initial stage of the process model and appeared to begin at varying stages for different participants, partially dependent on their level of knowledge in relation to WRs.

4.4.1 Negative Expectations for Young People and Raising Hopes for Parents

Interestingly 'Anticipating' typically led to 'Negative Expectations of Young People' and 'Raising Hopes for Parents', showing somewhat divergent views. This appeared a more positive form for parents due to their hopes that WRs would provide an opportunity to obtain information and be involved in decision making. This parallels with Bains & Vassilas' (1999) and Wagstaff's (2003) research where the relationship between involvement in decision-making and a more positive WR experience was reported. In the current study, young people appeared to hold more negative expectations regarding the prospect of attending WR but expressed a desire to be involved in the decision-making process. Such issues appear to be of fundamental importance during adolescence where a perceived lack of control in self-decision-making processes can detract from the desired independence associated with this period of development (Geldard & Geldard, 1999).

4.4.2 Attendance as Forced Choice

With the exception of one participant attendance at WR was seen as a forced choice' For young people this related to a desire not to be talked about in their absence and to be present so as to defend their behaviours and express their wishes. Past research has shown that adolescents are often especially concerned about confidentiality and tend to prefer to be present during discussions which involve them, especially if their parents are also present (Rutishauser, Esslinger, Bond & Sennhauser, 2003). Adolescence also emphasises the process of individuation, in terms of separation from parents and the desire to become an individual in one's own right. (Geldard & Geldard, 1999).

For parents, 'attendance as forced choice' paradoxically resulted from the positive expectations they held about what may be achieved from WR attendance, in particular the chance to be involved in their child's care. Furthermore, concerns regarding how staff may perceive their absence also contributed to the sense of WR attendance being essential. This echoes research which demonstrates that parents whose child is in inpatient care can experience feelings such as guilt, sorrow and shame and will engage in help seeking behaviours in order to reduce such negative feelings (Puotinieme, Kyngas & Nikkonen, 1999; Puotinieme & Kyngas, 2004).

Forced choice can also be considered within the process of cognitive dissonance (Festinger, 1957). The motivation to reduce this discomfort results in a change of one of the cognitions. In this instance, dissonance occurred for young people who did not want to attend but also did not want to be talked about in their absence. For some parents dissonance occurred when feeling the need to attend despite feeling extremely anxious about the prospect of doing so.

4.4.3 Increasing Anxiety

Prolonged waiting appeared to increase anxiety as this typically resulted in participants ruminating about the reason for the delay and speculating what their own WR may involve. This is consistent with the importance of punctuality as a predictor of positive experiences in both WRs (Wagstaff, 2003) and in general consultations (Williams, Wienman & Dale, 1998).

Increased anxiety can also result from an initial lack of information about WRs (Foster, Falkowski & Rollings, 1991). Their findings stated that participants expressed a desire to be given more information prior to attending their first WR. Similarly, Hunter, Grunfeld & Ramirez (2003) emphasised the importance of preparing patients' for breast care consultations in order to reduce anxiety.

4.5 Main Category 2: Managing Immediate Impact

'Managing Immediate Impact' refers to the way in which participants attempt to manage both the impact of attending their first WR and significant events occurring at subsequent WRs. Many participants' accounts reflected the first WR as a key moment in their inpatient experience.

4.5.1 Feeling Judged

'Feeling Judged', expressed predominantly by young people, related to perceptions of being judged by staff and parents, whereas parents typically felt judged by staff. Parents' concerns arose from their preconceptions regarding the views of health care professionals towards parents whose child "ends up" in inpatient care and echoes Wagstaff (2003), whose participants felt judged by the staff regardless of any evidence to indicate this was the case.

Concerns about feeling judged may be understood as a function of the attributions of guilt, shame and blame for having a child in psychiatric inpatient care and perhaps concerns regarding failing their child (Puotinieme, Kyngas & Nikkonen, 1999). Some parents in the current study made references to such feelings, though Harry questioned whether such fears were self-generated, rather than implied by staff.

4.5.2 Active Avoidance

Another way in which participants appeared to manage the impact of WRs was through 'Active Avoidance' which appeared to act as a coping strategy adopted by participants to avoid thinking about the impact of WRs during the week. Understandably this proved more difficult for young people, who were resident where WRs took place. However, by concentrating on other aspects of their inpatient care, they appeared, to some extent, to be able to actively avoid the negative impact of the WRs. Parents found active avoidance easier using sources external to the unit, such as work and hobbies to distract them and to maintain a normal routine. Both parents and young people appeared 'forced out' of this avoidance during WRs.

Psychodynamic defence mechanisms such as detachment, denial and avoidance have utility to understand such a process. Participants appeared to use detachment to keep uncomfortable matters from conscious experience and perhaps to contain anxiety (Jacobs, 1998).

4.5.3 Intensifying Emotions

For most participants WRs were reported to result in an intensifying of emotions as they had the tendency to further exacerbate negative feelings and moods that may have existed before

entering the WR. Participants used words such as angry; frustrated; upset; and scared in their accounts. It is possible that such intense emotions were experienced at WRs as participants were 'forced out' of avoidance and were suddenly faced with many emotive issues.

In an attempt to manage the impact of these intensified emotions, participants appeared to adopt emotion-focused coping strategies similar to those suggested by Lazarus & Folkmann (1984). In particular, emotion focused coping aims to alleviate emotional distress by using processes such as distancing, and selective attention in order to derive positive values from negative events. In the current study emotion –focused coping appeared to be used by parents in order to maintain hope and optimism when faced with distress as a result of WRs. This echoes Puotiniemi, Kyngas & Nikkonen (2001) who reported that parents with a child in inpatient care use optimism to help cope with the difficulties associated with being separated from their child.

4.6 Main Category 3: Seeking Understanding

All participants expressed the importance of feeling understood and this category represents the active process participants went through to achieve this. Young people typically sought out other residents to share their experiences whilst parents sought information from health care professionals and debriefed with each other to increase their understanding.

4.6.1 Importance of Shared Understanding

Young people's accounts demonstrated the sense of feeling understood almost exclusively by their peers which was associated with attending WRs in 'patient status.' Parents' accounts supported the exclusivity of their child's experience. This is consistent with

Piagetian developmental theory, particularly the stage of 'formal operations' where adolescents are able to consider the views of others and similarity of views becomes increasingly important (Inhelder & Piaget, 1958; Elkind, 1968).

The purpose of patient identification and peer comparison in participants' accounts are also consonant with psychological theory regarding social comparison processes (Festinger, 1954). The need for social comparison increases when patients experience greater uncertainty which was often an outcome of WR attendance. Participants sought support from those in the same situation as a means of providing reassurance and validation regarding their own experiences. Similarly, Balance Theory (Newcomb, 1981) is applicable as relationships are perceived as more likely to work when they are between two people who agree on some topic, with shared views of WRs being evident for all young people in the current study.

4.6.2 Seeking Information

The intermediate category of 'Seeking Information' served as an attempt to better understand WRs and treatment within the inpatient unit and was most typically engaged in by parents whilst the WR was taking place. There are parallels here with literature on information seeking during consultations within primary care (William, Weinman & Dale, 1998) where provision of information typically leads to higher satisfaction levels (Bains & Vassilas, 1999; Bramwell & Wiendling, 2005). Information helps parents understand their child's difficulties and extenuates their feelings of guilt. This has parallels with the parents' views described by Foster, Fallowski & Rollings (1991) who reported the importance of obtaining information from WRs. A lack of information for both parents and young people

appeared to correlate with a more negative WR experience in the current study and for participants in the study by Armond & Armond (1985).

4.7 Main Category 4: Readjusting Expectations

This category refers to the process of 'Readjusting Expectations' about WRs, with young people typically taking longer to revise their view than parents did. This could be explained by literature that suggests it will take children longer to adapt to being an inpatient than it will parents to adapt to having a child in inpatient care (Puotiniemi, Kyngas & Nikkonen, 2001; Puotiniemi & Kyngas, 2004).

4.7.1 Considering Reasons Behind Change

This intermediate category refers to the process that participants appeared to engage in when considering reasons behind changed views about WRs. Participants' accounts demonstrated that parents acknowledged a wider range of external factors as contributing to their revised views including: the role of staff; the support from their spouse and the overall impact of attending WRs. This is demonstrative of an external locus of control (Rotter, 1966).

Conversely, young people demonstrated a more internal locus of control as they felt that their revised views were attributed to improvements in their functioning, improved mood state and increased self-confidence, for which they felt personally responsible. The researcher hypothesises that for young people this relates to the importance of having a sense of personal control, cited as an important feature of adolescence (Geldard & Geldard, 1999).

4.7.2 Main Category 5: Further Consolidation of Experiences

The final stage in the process model related only to those participants who had been discharged, where it appeared that a further consideration of WR experiences took place. This possibly occurs as a result of the need for time and space away from the unit in order to fully consider their WR experiences. Also relevant is the stage of 'Adaptation' participants were at, with those still attending WRs being at an earlier stage in the process than those who had been discharged. Participants such as Suzie and Jordan commented that they would not have been unable to fully consider their experiences whilst still involved in the health care system. This has parallels to patients attending primary care consultations who often find it difficult to express negative views of their care, whilst still in receipt of it (Like & Zyzanski, 1986; Thorsen, Witt, Hollnagel, & Malterud, 2001).

4.8 Implications for Theory

In the sparse and generally poor quality literature examining experiences of WRs there has been no attempt to relate findings to theory. However, the current research has produced a potentially useful theory grounded in participants' accounts and has related findings to relevant concepts and literature in the field of psychology. In particular: theories of developmental psychology; adolescence; social psychology; and experiences of general consultations.

4.9 Implications for Clinical Practice

The findings from the current research have a number of implications for clinical practice in relation to the conduct of WRs. Support has been found for the 'Code of Conduct for Ward Rounds' (Wolf, 1997) which emphasises the importance of ensuring that WRs are held on

time, that staff numbers are kept to a minimum and that introductions are made by staff unfamiliar to the SUs. In addition the current research would emphasise the following:

- The importance of preparing SUs more fully before they attend their first WR in order to reduce anxiety.
- To tailor the level of information to each individual SUs needs, so as to not raise anxiety for those who may feel overwhelmed with too much information.
- To provide ongoing support outside the WR environment for SUs who find this a particularly stressful experience.
- To provide advocacy to SUs who find it hard to contribute during WRs.
- To ensure that only those staff key to the SUs care attend WRs and to seek permission from service users for additional staff to observe from behind the screen in the adjoining room

Inpatient care is widely acknowledged as being a stressful time for both adolescents and their parents (Puotiniemi, Kyngas & Nikkonen, 2001; Puotiniemi & Kyngas, 2004) and it is therefore of fundamental importance that events such as WRs that aim to assist SUs and their carers are managed in a productive and supportive manner that does not prove detrimental or distressing.

4.10 Methodological Critique and Limitations

This study had an adequate sample size for qualitative research and consisted of participants that theoretical sampling suggested would be interesting to recruit. It became apparent through the use of theoretical sampling at a relatively early stage of the research process, that it was important to sample young males and current residents. The researcher was able to sample sufficient numbers of these groups and ensure that the themes emerging from their data were suitably saturated.

However, there were two exceptions to this which related to 'Recognising the Positives' and 'Living with the Negatives.' These findings emerged late on in the data collection and were not suitably saturated. Although their status as lower level categories is demonstrative of this, further exploration would have proved useful.

A further limitation concerns the fact that the participants consisted of a self-selecting sample who responded to an invite to participate. It may be argued therefore, that this method of sampling provided access to participants who were keen to discuss their WR experiences. However as participants shared both positive and negative WR experiences it is hoped that a balanced view was obtained.

Silverman (2000) asserts that it is important when selecting cases, to seek out negative instances that are not likely to support the developing account. In this current study, Charlie, the parent whose job in the field of health care afforded him an informed knowledge of WRs, did this to a point. However, it would have been helpful to extend the use of theoretical sampling further to recruit additional participants who may have held a more ambivalent attitude towards WRs.

It is now generally accepted that the qualitative researcher cannot be a blank slate, which necessitates ownership of any attitudes and views that may have influenced the analysis. The researchers own belief framework and professional background will have influenced how the data were viewed (see Critical Appraisal). Steps taken to increase reflexivity and to gain an awareness of the researcher's personal contribution to the analysis included the coding of sections of the transcripts by the researcher's supervisor and peers, the constant comparison method and theoretical sampling.

Regarding transferability of findings, the current findings were grounded in the accounts of participants in this study and are not necessarily representative of all WR experiences. However, a number of the findings appear to resonate with previous research and theoretical perspectives and therefore the findings from the current study may go some way to explaining WR experiences for participants in other settings.

4.11 Future Research

The main category of 'Further Consolidation of Experiences' emerged at the later stages of analysis and was not fully saturated. Further sampling may have resulted in the emergence of more salient material. Experiences of male inpatients are also worthy of investigation, especially within settings where males have a minority presence. Peer support and understanding appeared a strong theme in the current study it is worth investigating whether potential gender differences exist in regards to this matter. Finally, it would be interesting to conduct a longitudinal piece of research where the participants WR experiences are measured over the course of their attendance and at a suitably defined follow up period. This would determine the extent, if any, to which participants experiences changed over time and may further inform the core category of 'Adaptation' which emerged in this study.

4.12 Conclusion

WRs play a pivotal role in inpatient care and it is essential that the way in which they are experienced by SUs and their carers is understood. Despite this it has remained an under investigated area with the current research providing the first theoretical account of this phenomenon. The current findings indicate parallels with literature on consultation experiences; classic and contemporary psychological theory. The process of 'Adaptation' is an important psychological process for SUs which appears to make WRs a more bearable experience. It is hoped that the findings from this study will give voice to SUs about their WR experiences, something which appears long overdue.

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Paper Three

Critical Appraisal

CRITICAL APPRAISAL

5.1 Overview

It is not possible to document the entirety of my research journey with its twist and turns, but it is hoped that this chapter will give a flavour of the research experience and highlight some of the issues that emerged through the endeavour. It tracks the development of the research from initial choice of study area to the final write up. It is intended to be a reflective chapter, highlighting my journey through the research process, the positive and negative experiences I encountered and the insights that I gained along the way.

5.2 Development of Research Project

5.2.1 Choice of Research Area

My initial interest in WRs began after I had attended a number of WRs during my first year of clinical training as part of my older adults and adult mental health placements. My personal experiences of WRs were a mixture of positive and negative encounters, but I recall being struck by feeling intimidated and overwhelmed, even during the more positive experiences. I had wondered at the time if some of these feelings resulted from having attended the WR in the relatively junior role of 'Trainee', when compared to other staff members present. I became curious as to what the ward round (WR) experience was like for SUs, who, I hypothesised, may feel in an even more powerless position.

My curiosity prompted me to conduct a literature search on the area. The results left me feeling somewhat disheartened; the sparse literature that did exist, focused mainly on experiences of WRs for staff members or their use as an educational forum. I became keen to conduct research exploring the experiences of WRs for SUs, and was particularly

interested in seeking the accounts of adolescents and their parents. Literature suggests that both these groups face difficulties when the child is in inpatient care (Puotiniemi, Kyngas & Nikkonen, 2001; Puotiniemi & Kyngas, 2004). As the WR appears a fundamental part of the inpatient experience, this felt an important area to explore. After having approached an inpatient mental health unit for adolescents, and having had conversations with key personnel, it was agreed that I would undertake my research in this setting for my doctoral research project.

5.2.2 Choice of Methodology

The research question, which aimed to gain an understanding of SUs accounts of their WR experiences, indicated that a qualitative method of enquiry would be most suitable.

Furthermore as I had adopted a quantitative approach in two previous substantive research projects, I was keen to gain some experience and knowledge of a different methodology for my doctoral research study. Grounded theory (GT) was chosen for two main reasons. The dearth of literature in this area suggested that a theory-generating methodology would be useful in order to provide a framework to understand the data and to increase the literature base in this area. Secondly, it provided a structured methodology suitable for novice qualitative researchers, in particularly the account developed by Charmaz (2006).

5.2.3 Choice of Epistemological Stance

The decision regarding which epistemological stance I would take proved problematic. I had been advised that this decision could be made once the initial data had been collected, but this was an issue that I personally struggled with as I felt such decisions would inform the interaction with participants, the interview questions and the interview process. I therefore did considerable amounts of reading (Madill, Jordan & Shirley, 2000; Charmaz,

2006) and decided that the social constructionist (SC) standpoint would be most appropriate as the SUs I would be interviewing consisted of adolescents and parents, from diverse backgrounds and this stance would capture the wide-ranging contexts relevant to their experiences. Although I remained open to a revision of this stance, I found that during the interviews a number of participants appeared to be constructing their experiences through the discussions we were having. Furthermore some appeared to be considering some experiences for the first time during the interview, which reassured me that the decision to adopt a SC standpoint had been the most appropriate.

5.2.4 Data collection

My field supervisor, who was located within inpatient unit where the research was being conducted, had agreed to take the lead on the role of recruiting. However, a month after the study had been passed by the ethics committee she left the service on maternity leave. This led to delays in the recruitment process as additional meetings were required with staff in the service to find an alternative person to oversee the process. Being external to the service proved difficult when needing to chase up recruitment, resulting in a protracted and frustrating process of obtaining sufficient numbers of participants. However, the role of an external researcher did have some advantages in that I believe my status resulted in participants feeling more able to speak openly of their WR experiences than in talking to an internal researcher, perceived as being directly involved with the process.

5.2.5 Interviewing

Interviewing raised several interesting issues. I had anticipated that interviewing adolescents may have been a difficult experience as I was unsure to what extent they would engage with the questions. Thankfully, all participants appeared to talk openly and freely of

their experiences. However, this possibly represents a self-selection bias, with the participants who opted in being more willing to share their experiences, and those who may have been reluctant to discuss them choosing not to take part.

Regarding the construction of interview data, I assumed that both interviewer and interviewee were active in creating and interpreting meaning in line with a social constructionist version of GT (Charmaz, 2006). The interviews were constructed around open questions, in the hope of allowing the interview to be guided by each participant's account (Smith & Heshusius, 1986). I became aware of the extent to which participants often appeared to be considering their experiences for the first time during the interviews, referring to "not having thought about it before" or "just realising this" and appeared to be constructing their accounts more fully during our interaction as the interview progressed. This proved a fascinating insight, and I wondered whether without these comments, I would have been able to see that they were considering such experiences for the first time.

The interviews had the potential to be emotionally difficult for participants. In an attempt to try and manage this during the interviews I monitored for any observable signs and verbal responses which were indicative of distress and shaped questions accordingly. Recognising the potentially distressing nature of the experiences the participants shared increased my awareness of the tension between researcher and clinician roles when conducting clinical research projects. This was especially so when one participant became distressed during the interview. However, after a short break she expressed the desire to continue.

5.2.6 Data analysis

In accordance with GT methodology, data collection and analysis were conducted in parallel (Strauss & Corbin 1994; Charmaz, 2006). Analysis followed an adaptation of the social constructionist stance (e.g. Charmaz, 2006). This was in order to acknowledge the role of participants' social contexts and social constructions of their WR experiences sufficiently (Rennie, 1998).

Conducting the analysis proved an interesting experience, especially for someone more familiar with quantitative forms of analysis. I consider myself to be an organised and methodological person by nature and through the process of data analysis I experienced a number of difficulties as a result of this. At times the data analysis felt unstructured, at least in comparison to the statistical analysis I had used previously. I often experienced moments of uncertainty regarding my interpretations of participants' accounts. Initially, I felt the need to constantly go back from the initial line by line codes to the original data before making any attempt to move towards more focused codes.

On finalising the main categories and themes within them, and in the production of the process model, I returned to my original transcripts to check that the model and the codes were grounded in participants' accounts. I found this process enjoyable and reassuring, especially being able to use quotes directly from participants to justify my construction of the category names. In returning to the original transcripts to check the codes I had generated, I was reassured I had remained faithful to participants' accounts and this also confirmed the fit of the theory. During the period of data collection and analysis I reconciled uncertainties and difficulties by recording analytic decisions within my research journal. This also included justifications for decisions that were made. In setting up an audit

trail, it enabled me to remain organised yet at the same time be flexible and open to pursuing new leads emerging from the data.

5.3 Revisions to the Process Model

The final process model was developed after a number of revisions. The first model I produced was grounded in the data, but on reflection and through invaluable discussions during supervision, I became aware that I had produced a highly intellectualised and cognitive model. This was problematic as the model lacked many of the emotional aspects that were evident in many of the transcripts. Particular attention is drawn to main category two (see Table 3), relating to the impact of WR experience. This is the area in which the emotive elements had been missed.

Table 3: Comparison of Categories within the Initial and Final Process Models

INITIAL PROCESS MODEL	FINAL PROCESS MODEL
Core Category: Adaptation	Core Category: Adaptation
Main Category 1: Anticipating	Main Category 1: Anticipating
Main Category 2: Attempting to Understand	Main Category 2: Seeking Understanding
Main Category 3: Considering Impact Considering positive impact Considering negative impact Contemplating other's views Processing the impact of ward rounds	Main Category 3: Managing Immediate Impact Feeling under the spotlight Active avoidance Intensifying emotions Feeling judged
Main Category 4: Readjusting Expectations	Main Category 4: Readjusting Expectations
Main Category 5: Consolidating Experiences	Main Category 5: Further consolidation of experiences

Whilst it was reassuring that participants felt able to share some of the more difficult experiences of WRs with me, at times it was understandably difficult to hear that the WRs generated negative emotions such as frustration, anger and anxiety. Given that participants' accounts included such emotive words I had to question why I had somehow overlooked them in the development of the initial process model.

On a professional note, in acknowledging the difficulties and negative experiences that WRs generated for SUs, it is possible this resulted in my feeling the need to offer an immediate solution to try and make the WRs more bearable. As an external researcher this was not possible. The fact that I chose the career choice of clinical psychologist may also be worth considering here. I chose this career out of a desire to work with people in a way that could provide assistance and support with difficulties they were experiencing. On reflection, during the interviews, and the subsequent process of coding and analysis, I may have attempted to cope with the feelings of being powerless to provide this support by an unconscious avoidance of the emotive elements which were indicative of such difficulties.

I reconciled this by taking the view that having conducted research which identified such experiences to be important, and in disseminating the findings to the service at a later point in time, there was hope that changes may be made to make the WRs a more bearable experience. Although this may not be for the participants in the current study it is hoped that future residents in the unit may benefit.

A further factor I feel contributed to the lack of emotion in the initial mode was that the majority of the interviews were conducted during my second year, whilst on a learning disability placement in another health authority region. However the bulk of the analysis and the construction of the model occurred during my third year, whilst conducting a specialist child placement in a service which was closely associated to the unit where the research had taken place. The placement choice had not been at my request but at the suggestion of the University. This left me feeling somewhat awkward as at the time of interviewing I had told participants I was not working in the service in which the research was taking place, which at that time was indeed the case. I hypothesise therefore that on my

third year placement, I became to feel part of the system associated with where the WRs were conducted. This may have increased the need to avoid becoming too aware of the emotive feelings WRs generated for participants. Interestingly, I noticed that the revision of the model and the associated writing process freed up considerably after completion of my child placement.

On a more personal note, I have considered how my own upbringing may have related to me having produced an initial model lacking emotional content. As an only child I became the carer for my Mother during a recent episode of illness. My Mother was reluctant to have treatment, but was strongly encouraged to do so by myself. Her illness resulted in a reversal of the parent/child role with me taking on a lot of parenting duties in her care. It is possible therefore that unconsciously some part of me perceived similarities between the experience of my mother and the young people in the study, in that both were strongly encouraged to pursue treatment against their choice. In recognising that WRs generated many negative emotions for the young people who did not want to attend, this possibly resonated with me in a way that produced feelings of guilt at having so strongly encouraged my Mother to accept treatment, despite her best wishes.

I believe that both the personal and professional factors combined to result in the initial oversight of the emotive elements that needed to be present in the process model. Due to the process of constantly re-examining the data, guidance from supervision and having recognised the professional and personal factors which contributed to the oversight this was rectified in the final version of the model. I found the process of moving from the initial to the final process model, and ensuring that I remained reflexive and true to participants accounts one of the most challenging but interesting aspects of the research journey.

5.4 The Process Model as a Parallel to My Personal Research Journey

When writing up the analysis section I became aware that there appeared to be parallels between the main categories within the process model and the process by which I had conducted the research. At the outset of my research journey there was an initial process of 'Anticipating', when initial ideas were forming, and I was awaiting feedback from my submission to the ethics committee. This involved me hypothesising about the unknown and feeling that other people held control over an issue of importance to me, which had parallels to SUs descriptions of their experiences of WRs.

The process of 'Seeking Understanding' permeated the entire research process as the main aim of the study was to gain an insight into SUs experiences. In order to do so I was required to engage with data to reach an understanding of their accounts. 'Managing the Immediate Impact' of the research was also evident for me throughout the entirety of the study. For SUs the initial impact of attending WRs appeared most difficult to manage. Personally, the period of the research which I felt required most management occurred during the latter stages. At this time I was required to meet numerous research deadlines alongside managing the impact of attending two clinical placements, academic teaching and issues in my personal life occurring at the same time. Other areas I needed to manage the impact of related to hearing the distressing accounts of WR experiences, which have been discussed previously.

The process of 'Readjusting Expectations' in the context of the research related to the process of revising the interview questions as a result of theoretical sampling. Finally, there existed similarities between the last stage of the process model and the latter stages of the research process. Regarding research, a 'Further Consolidation' of views took place as a

consequence of latter stages of analysis, finalising of codes and categories and developing the final process model.

5.5 Power in Relation to Ward Rounds and the Research Process

As stated previously, my initial interest in researching experiences of WRs emerged after having attended a WR during my first year of clinical training. Personally, I found this an interesting but intimidating experience. I had found contributing difficult and on reflection attributed that as possibly being a result of my relatively junior capacity compared to the other members of staff who were present. This led me to wonder what the experience was like for service users. In an attempt to not let my own experiences bias the research process, I ensured that there were no questions in the interview schedule directly relating to power issues. However, I intended to remain open to this theme should it emerge from participants' accounts. On reflection, in my attempt to not let my own experiences and view bias the findings, I believe that when analysing the data, although the theme did emerge, I overlooked its importance. On re-reading the transcripts, though the theme of power was not sufficiently present to constitute one of the main categories, it did appear on numerous occasions as a sub-text in participants' accounts.

The first way in which power differentials were possibly influential related to the differences in power between the researcher and the researched. Although as the researcher, I viewed the interviews in terms of an equal co-construction between myself and participants of their experiences, for the participants, the interaction may have been construed more in terms of one between service users/psychologist. If this were the case, it may have unintentionally and unavoidably served as a parallel process to their feelings of powerlessness when attending WRs. Interestingly, the feeling of powerlessness were

something I experienced personally when awaiting for a decision from the ethics committee, where I felt others had the power and control over a decision that was very important to me and my future.

Power differentials were also evident within a number of other relationships relevant to this research which may go some way to explain some of the different findings between young people and parents. For example, within the main category of “Anticipating”, young people were seen to anticipate the WR negatively, whereas for parents, the prospect of attending appeared to raise their hopes. These very different ways of approaching the WR may well relate the differences in power between the two groups. Young people, who typically referred to themselves as “the patient” would arguably feel in a much more powerless position than parents. This was particularly relevant for the “feeling judged” category. Furthermore, the developmental stage the young people were at may also be relevant as despite adolescence being a stage where a desire for power and independence often emerges, being an inpatient within the unit may have served to prevent this from being possible.

Within participants accounts there were a number of examples of both young people and their parents engaging in behaviours which were possibly an attempt to take some of the power back. For example, for young people in the category “Adapting Behaviour” this was a process they would typically engage in in order to avoid a negative experience at WR. Although this appeared to be important in terms of being able to predict the WRs contents, it is possible that the young people also saw this as an opportunity to have some power in determining these contents. Similarly, for parents, their desire to be involved in the decision-making process, although framed in the context of wanting to be kept informed, may also be an attempt to feel in a more powerful position. Finally, for both young people

and parents the fact that all but one participant felt attendance was a forced choice may also relate to a sub-text of power. The fear was not being present when discussions were taking place about them, resulting in them feeling that they may be judged in their absence and be unable to defend themselves. Therefore in order to feel in a more powerful position, they chose to attend the WR, despite many feeling anxious about doing so.

5.6 Supervision

Regular meetings were held with my academic supervisor which helped ensure that the emerging theory was grounded in the data and encouraged reflection and explication of the developing model. The view of someone not as immersed in the data proved invaluable, especially in relation to how the emotional elements of participants' accounts had been overlooked from the initial model. My field supervisor's expertise in working with adolescents and their parents added a contextualised view of the data as well as a forum for testing emerging interpretations. My field supervisor was also supportive and helped remind me of the importance of the study and its potential utility to SUs and the service where it was conducted. This helped to maintain my motivation and interest in the project through the more challenging and demanding times of the research process.

5.7 Ensuring Quality in Qualitative Research

One avenue by which I could gain reassurance that my research was being subjected to sufficient quality checks was by attending a 'qualitative support group', however this proved a mixed experience. On the one hand I found it supportive to exchange transcripts with peer researchers and to conduct GT coding on each others interviews. This reassured me that the codes I had generated were consistent with those generated by other group members and reduced the likelihood that the codes had arisen from any preconceived ideas or beliefs I

may have held and provided a forum in which to discuss initial drafts of the model. Furthermore, myself and another member of the group paired up as 'peer debriefers' and met weekly to continue the most productive aspects of the group, such as coding each other's transcripts, discussing the codes assigned and tracking developments to the models emerging from the data. However, at times the group left me feeling somewhat anxious. This was usually when we had attempted to engage in complex epistemological debates when there was not a sufficient amount of time to do so. This helped me to develop the capacity to tolerate uncertainty and promoted further reading where necessary.

5.8 Reflexivity

A number of researchers have challenged the suggestion that GT analysis can be a purely inductive procedure (e.g. Dey, 1993; Silverman, 1993). Social constructionist critiques have highlighted that the researcher inevitably shapes the inquiry through the experience, meaning and interpretation they bring to it (Henwood & Pidgeon, 1992). Reflexivity refers to the researcher's observations of the way they conducted their research and informs the reader about the extent to which the researcher's stance and assumptions influenced the analytic process (Charmaz, 2006). Adopting a reflexive stance renders the process of analysis more transparent for the reader. By engaging with the data in this way it can help ensure that the analysis represents the accounts of the participants more accurately.

To facilitate this I documented thoughts and decisions relating to the research process in a reflective journal. This contributed to a 'paper trail', also including transcripts, examples of coding and memos which opened the research process to wider evaluation (Lincoln & Guba, 1995, Henwood & Pidgeon, 1992). This was especially useful when assigning category names and the development and revision of the process model.

Reflexivity was also useful in that it enabled me to become more aware of the influence of my theoretical interests during the analysis and how it was important to be explicit about the origin of my ideas, and to reflect upon how my own constructions of participants' accounts may have influenced the shape of the interviews and the development of the model and the core category. This was particularly important when I noticed the similarities between my process model and the experience cycle within PCP (Kelly, 1955). I was keen to ensure that my own interest in PCP had not influenced or biased the production of this model. This was done by a constant comparison of the emergent categories within the model and the original transcripts. Furthermore, as the experience cycle by definition relates to the way in which people experience events, it is highly probable that this could be readily applied to participants' experiences of WRs in this study.

5.9 Limitations of the Current Research

One of my initial concerns regarding qualitative research was the extent to which data would be saturated. This largely emerged from the initial feeling that compared to the large data sets I had worked with on previous substantive research projects; a final sample of ten was relatively small. However, on reflection with the exception of 'Recognising the Positives' and 'Living with the Negatives' that require further exploration the other categories were suitably saturated.

Although theoretical sampling enabled me to recruit participants based on gaps in the emerging data, there remains a limitation of the final sample. The sample was self-selecting, consisting of those who responded to an invite to participate and therefore only

provided access to participants who were keen to discuss their WR experiences. However, within the constraints of this research it proved difficult to overcome this.

Through the completion of my research journal I became aware of the fallacy of the researcher as a 'blank slate' especially in relation to the initial model that I had constructed which as discussed previously lacked emotional content. It also highlighted the importance of constantly taking a step back to ensure that it was not my preferred way of working clinically that had influenced the interpretation of the analysis

5.10 Timescale of Research

The delay in recruiting had a subsequent knock on effect on the rest of the research process, leading to the interviews, transcription and coding all being finished later than had initially been intended. One way in which to prevent further delays was the option of seeking someone out who would be able to conduct the transcribing on my behalf. However, I resisted doing this as I felt that the best, if not only way; to fully immerse myself with the data was to conduct the transcription myself. I had fully transcribed the first seven interviews and felt that this process had been invaluable in gaining an understanding of the data. I therefore made the decision to take additional research leave and complete the transcribing of the remaining interviews myself.

5.11 Development of Research Knowledge

This study developed my research knowledge in five main ways. Firstly, it highlighted the importance of adaptability when unforeseen circumstances impact upon the research process (in this case the maternity leave of the field supervisor). The subsequent delay in recruitment that led to this was initially anxiety provoking as it resulted in me feeling out of

control of an important aspect of the study. Interestingly, this is possibly a parallel process to the lack of control over issues of importance that some participants described experiencing during WRs. It was important to remain focused and positive during this time and to concentrate on the areas of the research which remained within my control. Assistance with recruiting was particularly important in the latter stages of data collection when using theoretical sampling and a more specific kind of participant was required to be recruited (e.g. male adolescent, current residents and their parents).

Secondly, due to the rigid time constraints within the doctorate in clinical psychology research project it was essential that time management skills were used in order to ensure deadlines were met. This required the need to be more flexible than I had been in the past when I would typically complete one piece of work before commencing another. During the research process there were numerous tasks which needed to be carried out simultaneously: data collection; data analysis; transcribing and writing the initial chapters of the research report. Once I had adapted to this way of working, the research process became more manageable.

I found meeting the strict rules regarding word counts per thesis chapter a constant battle, in particular with the Method and Analysis chapters. As someone new to GT, I often felt the need to fully justify decisions, provide an in-depth explanation of code names and so on. To do this, along with the reporting of the standard issues one would expect to find in a Method and Analysis section proved immensely difficult due to very limited word constraints. In particular, having the participants quotes counting towards word counts in the Analysis proved problematic. Although I attempted to resolve this by the inclusion of additional

quotes in the appendices I remain unsure of how comprehensive the feel of this chapter will be for the reader.

The third point relates to my development as a researcher whilst conducting this project. I believe that my interviewing style improved throughout the process of data collection and I gained a valuable insight into GT analysis. Initially, the interviews were intended to be as open as possible in order to facilitate the generation of data meaningful to participants. However the need to adopt a more direct approach emerged later in the interviewing processes, when using theoretical sampling to explore issues of interest emerging from previous interviews.

I also gained some important insights as a clinician, which leads to my fourth point. Understanding the difficulties that can be experienced for SUs during WRs was an invaluable insight to have gained. This provided a more contextualised understanding of an area that to date had not been explored in any depth with SUs. I anticipate that the findings from this research will be of benefit should I have occasion to attend WRs in a professional capacity in the future. Furthermore, the findings also indicated that the wider context of inpatient care can often serve to impose invisible barriers to communicating with health care professionals. This is an area worth considering in any clinical context, but especially those in which clients are attending against their will, or feel obliged to attend for a reason other than their own desire to do so (e.g. to satisfy a partner or at the request of another health care professional).

The fifth and final point relates to the issue of context. One of the most interesting findings from the study was the need to consider the importance of context when attempting to

understand experiences of any phenomenon, be it relating to clinical work or within research studies. In particular this related to whether participants were a current or former resident (or parents of a current or former resident). The language used by participants who were interviewed whilst still attending WRs, appeared more hesitant and more reassurance was required regarding the confidentiality of the research. The way in which participants accounts appeared to some extent constricted by the fact they were still receiving care from the service is useful to bear in mind in a therapeutic context. As a psychologist I realised that the clients under my care may also feel certain limits to their comfort zone in sharing more negative experiences of their care with me and that I should pay more attention to this in future clinical work.

5.12 Final Reflections on the Conducting of Qualitative Research

During the initial stages of the research process I spent a significant amount of time considering that participants may find some elements of the interview distressing, and had ensured measures were put in place to support them should this happen. One thing I had not anticipated was that for some participants the interviews would prove a positive and helpful process. The interviews seemed to provide some participants with a sense of validation that their views and experiences had been recognised by another party having shown interest. A number of participants expressed the view that it had been helpful to talk about their experiences and were pleased that someone felt their views were important enough to research. This was especially true for parents. This and the dearth of literature in the area assured me that the study was needed, meaningful, and worthwhile.

Overall the journey of embarking on a qualitative research project resulted in invaluable personal growth both as a researcher and a clinician. It also enabled to me to gain an insight

into the challenges and rewards that GT methodology can provide for both researcher and participants. As a novice GT researcher the main lesson I learned was that being highly structured has disadvantages during some stages of the analysis. Coming from a quantitative background where right and wrong ways to conduct analysis are very evident, relinquishing such viewpoints was challenging, yet at the same time freeing and rewarding. Having acknowledged that it is acceptable to produce a 'good enough' account of the data that is true to the participants' voices liberated me and enabled me to gain more enjoyment from conducting the research.

5.13 Concluding Thoughts

Despite my initial uncertainty at venturing into the unknown territory of GT research, I found many positive aspects arising from conducting a qualitative analysis. Mainly, that SUs had been provided with an opportunity to share their experiences about a much under researched area. It is my hope that by producing a rich account of their WR experiences future service delivery will be better informed. In doing so it is hoped that the findings will act as a source of encouragement for those professionals attending WRs regarding the positive experiences SUs discussed, and may also help ensure that change is implemented to the areas of WRs they experience as more difficult. These hopes alone made the effort and challenges associated with conducting this piece of research more than worthwhile.

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Appendix 1



The
British
Psychological
Society

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> Notes for Contributors

Notes for Contributors

The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing



The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship (including personal acknowledgements and institutional affiliations) should be confined to the title page (and the text should be free of such clues as identifiable self-citations, e.g. 'In our earlier work...').

4. Online submission process

- 1) All manuscripts must be submitted online at <http://bjcp.edmgr.com>.

First-time users: Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).


Registered users: Click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

- 2) Follow the step-by-step instructions to submit your manuscript.
- 3) The submission must include the following as separate files:
 - o Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - 
 - o Manuscript title page template
 - o Abstract
 - o Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.
- 4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - 

Editorial Manager - Tutorial for Authors

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions: 
- British Journal of Clinical Psychology - Structured Abstracts Information
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA (<http://www.apastyle.org>).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct -



Code of Conduct, Ethical Principles and Guidelines

Principles of Publishing -



Principles of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the

page proofs

- Tables, figures, captions placed at the end of the article or attached as separate files

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Appendix 2

Manuscript Submission Guidelines:

Notes for Authors

Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology - cognitive, social, developmental, educational, clinical, health, forensic - as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research.

The journal aims:

- to firmly establish qualitative inquiry as an integral part of the discipline of psychology;
- to stimulate discussion of the relative merits of different qualitative methods in psychology;
- to provide a showcase for exemplary and innovative qualitative research projects in psychology;
- to establish appropriately high standards for the conduct and reporting of qualitative research;
- to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record;
- to place qualitative psychological inquiry appropriately within the scientific, paradigmatic and philosophical issues that it raises

Qualitative Research in Psychology will publish the following types of paper:

1. Theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
2. Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways
3. Debate section
4. Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Book Review Editor, although unsolicited reviews will be considered and the journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for Qualitative Research in Psychology, and not to have been submitted for publication elsewhere. All authors must assign copyright to Arnold (by completing the copyright assignment form). Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Article presentation

Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order.

The following items must be provided in the order given:

1) Title Page

Authors and affiliations

Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment his/her present address should be given as a footnote).

For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs and offprints will be sent) named with their telephone/fax/email contact information listed.

Abstract

Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content. This is not needed for observations or commentaries.

Keywords

Please provide at least 5-10 key words.

About the author

Please provide a brief biography to appear at the end of your paper. Click here for examples.

2) Text

Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading

1.1 Subheading

1.1.1 Subsubheading

Footnotes should be avoided. If necessary they should be supplied as end notes before the references. Do not use programming to insert these.

3) References

The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

For a book...

Hollway, W. and Jefferson, T. 2000: Doing qualitative research differently: free association, narrative and the interview method. London: Sage.

For an edited book...

Brown, L.M. 2001: Adolescent girls, class, and the cultures of femininity. In Packer, M.J. and Tappan, M.B., editors, Cultural and critical perspectives on human development. Albany, NY: SUNY Press.

For a journal article...

Madill, A., Jordan, A. and Shirley, C. 2000: Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. British Journal of Psychology 91, 1-20.

4) Acknowledgements

Authors should acknowledge any financial or practical assistance.

5) Tables

These should be provided on a separate page at the end of the paper and be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions

These should be provided together on a page following the tables.

7) Figures

Figures should ideally be sized to reproduce at the same size. However, the typesetter can manipulate sizing where necessary.

All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B) etc can only be used when the separate illustrations can be grouped together with one caption.

Please provide figures at the end of your paper on a separate page for each figure. Once accepted you will be required to provide a best quality electronic file for each figure, preferably in either TIFF, or EPS format.

For an information sheet about creating electronic versions of your figures please [click here](#).

Style

General:

Abbreviations should be spelled out when first used in the text. Full stops should be used in lower case abbreviations (e.g., i.e.) but not for capitals (SAS, ANOVA). Spelling can be either UK or US English but must be consistent throughout the paper.

Mathematical:

Numbers below 10 should be written out in the text unless used in conjunction with units (e.g., three apples, 4 kg).

Use spaces (not commas) within numbers (e.g., 10 000, 0.125 275).

Full points (not commas) should be used for decimals. For numbers less than one, a nought should be inserted before the decimal point . (e.g., 0.125 275).

SI units must be used. English units may appear in parenthesis following the SI units.

Permissions

It is the responsibility of the author(s) to obtain written consent from the original publisher and author(s) to use the following material published previously elsewhere.

1) All maps, diagrams, figures and photographs (forms are available from the publishers); 2) Single passages of prose exceeding 250 words, or scattered passages totalling more than 400 words from any one work. Please supply the publisher with full information for all work cited, including author, date published, publisher and page references. EU copyright extends to 70 years after the death of the author or 70 years after publication of a scholarly edition. Please forward all correspondence to the Journals Production Department, SAGE Publications Ltd, with your accepted manuscript.

Proofs

Proofs are sent to the corresponding author by pdf in an email to check for typographical errors. Modifications cannot be incorporated at this stage without incurring heavy costs hence the original text cannot be altered.

Offprints

The corresponding author only will be supplied with 25 offprints of his/her article. Additional offprints can be ordered at page proof stage.

Appendix 3

RESEARCHER'S NOTES ON GROUNDED THEORY

The Historical Context

The first description of grounded theory as a method of analysis was put forward by sociologists Barney Glaser and Anselm Strauss in their book 'The Discovery of Grounded Theory' (Glaser & Strauss, 1967). They initially conducted research which aimed to understand the experiences of terminally ill patients who were living in institutions. They focused on 'discovering' the subjective experiences of patients and what meanings were attributed to them by the patients.

One of the main aspects of this method is that it aims to develop a theory which is grounded in the data under analysis and thus is considered a more "bottom up" approach which is inductively driven. Glaser and Strauss, (1967) stressed the importance of understanding the ways in which people make sense of and construct their own realities. This inductive approach requires that the researcher begins the study with only a general idea of the area to be studied, which may see the literature review being delayed until later on in the research process. The aim of this being to allow the theory to emerge as the data is collected.

Charmaz (2006) states that by the 1960s quantitative methods, with their roots in positivism had overtaken more qualitative methodologies such as interviews, case studies and fieldwork to become the dominant methodology. Central tenets of positivism such as scientific logic, truth and objectivity separated fact from value but did not often result in the development of new theories being constructed. According to Charmaz (2006) the challenges put forward by Glaser and Strauss (1967) in response to this included arguing against:

- Seeing theory and research as separate entities.
- Beliefs that see qualitative research as being mostly useful when it is used as a precursor for more scientific quantitative methods
- The notion that qualitative methods were impressionistic and unsystematic
- Data collection and analysis having to occur at separate stages of the research process.
- General assumptions that qualitative research was unable to generate new theory

Developments in Grounded Theory

Since their classic statements on grounded theory in 1967, Glaser and Strauss have taken the method in somewhat different directions (Charmaz, 2000). Glaser persisted in the view that grounded theory is a method of discovery that enabled categories to emerge from data in order to explain basic social processes. However, Strauss (1987) however moved the emphasis of the method towards seeking which became the focus of the work conducted with Corbin (Corbin & Strauss 1990; Strauss & Corbin, 1998).

In a reaction to the new technical procedures put forward by Strauss and Corbin (1990) contends that it forced data into preconceived categories and in doing so contradicts the fundamental beliefs of the initial statement on grounded theory. However, despite Glaser's numerous objections to Strauss and Corbin's version of grounded theory, their book continues to provide a detailed account of the method which has aided students and researchers throughout the world.

In more recent years a growing number of researchers have moved grounded theory away from positivism in both Glaser's and Strauss and Corbin's versions of the method (Bryant, 2002, 2003; Charmaz (2000, 2006). Some of the guidelines within grounded theory such as coding,

memo-writing and sampling for theory development, and comparative methods are, in many ways able to be adopted and adapted to conduct diverse studies. Whilst some of these guidelines are in themselves neutral the way in which researchers use them are not. Nor are the assumptions they bring to their research and enact during the process. However if researchers are open and upfront about their own assumptions and consequent effect they may have on the research process this need not be problematic. Charmaz (2006) and Bryant (2002) contend that grounded theory guidelines can be used with twenty first century methodological assumptions and approaches.

Criticisms of Grounded Theory

Grounded theory, like all methods of analysis, be they qualitative or quantitative, has limitations and is open to criticism. Broadly speaking, as relates to grounded theory, the criticisms can be divided into those that refer to practical matters and those of a more epistemological nature.

Some authors have argued that from a practical point of view, in terms of data collection, grounded theory researchers are often too quick to treat participants' accounts as reflections of reality, rather than one version, or construction of an event as seen by that one participant. Furthermore, it has been argued that what is obtained is merely a product of the interaction between the researcher and researched. As it is impossible to ever fully know the reality of someone else's internal world researchers are therefore reliant upon the account provided by their participants and participants may censor the accounts they offer a range of reasons. For example, participants may feel shame or stigma, may feel unable to voice a negative opinion which may result in them either giving partial information or to be acquiescing. Participants may also be very conscious of the power imbalance between themselves and the researcher.

Although some authors suggest that respondent validation is one way in which the researcher can check the validity of their interpretations of the interview data, it is possible that this may also lead to acquiescence. So whilst asking participants to comment on the emerging theory is certainly appropriate, it is also potentially problematic. Respondent validation is also problematic in that some participants may never have thought of their experiences in such abstract terms or may not understand the theory that the researcher is presenting to them. It is therefore of fundamental importance to present concepts and theories to participants in language they can identify with. This is especially important when working with vulnerable groups such as children and adolescents or clients with a learning disability. Finally with regards to respondent validation each participant is only presented with some of the data (their own) to comment on and may find a complete and abstract theory which has been generated from other narratives as well difficult to understand, interpret or relate to.

A further criticism is that grounded theory studies often do not end in the generation of an all-encompassing theory and can simply provide a description of the data of a simple form of content analysis (Stern, 1994). This was a point of considerable debate for Glaser and Strauss who disagreed on the ultimate aim of analysis with Strauss arguing that complete theory was not automatically necessary. Similarly, Charmaz (2000) suggests that not generating a complete theory at the end of analysis is not problematic, as considerable conceptual description can be obtained that still provides the reader with insight and greater understanding of their participants' experiences, even in the absence of a complete theory. It is however problematic if no new insights into the phenomenon under investigation are offered.

The structured approach of data analysis and constant comparison, along with theoretical sampling should ensure the quality of the method. The researcher should allow themselves to

be guided by the data but must make sure that they do not stick too rigidly to it. Similarly data should guide theory but not limit it (Layder, 1993). Finally to address the point made by Stern (1994) the theory that emerges should be conceptual rather than simply descriptive in nature.

A further matter for consideration is the suggestion that grounded theory research runs a risk of producing analyses and results that simply represent the views and assumptions of the researcher (Schwandt, 1994). For example, the researcher might place greater emphasis on the data that supports their assumptions and neglect those that challenge their existing views which would bias the theory produced. However, there are systems discussed previously that can be used to minimise the risk of the researcher's biases influencing the research. For example, by the processes of memo writing, adopting the constant comparative method and by keeping a reflexive journal to aid the researcher space to reflect on the research process. It is also important to constantly attempt to ground the theory in the data being collected as this will help make the thought processes behind any decisions that are made and categories that are generated explicit and provide evidence to justify such decisions (Tweed & Salter, 2000).

GROUNDING THEORY REFERENCES

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Tweed, A.E. & Salter, D.P (2000) A conflict of responsibilities: A grounded theory study of clinical psychologists' experiences of client non-attendance within the British National Health Service. *British Journal of Medical Psychology*, 73, 465-481.

Appendix 4



Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
DERBY
DE1 1LJ

Telephone: 01332 868842
Facsimile: 01332 868785

24 May 2006

Ms Karen J Ceaser
13 Turner Road
Leicester
LE5 0QB

Dear Ms Ceaser

Full title of study: A Qualitative Analysis of Service Users' Experiences of Attending Ward Rounds

REC reference number: 06/Q2502/44

The Research Ethics Committee reviewed the above application at the meeting held on 18 May 2006. Thank you for attending the meeting.

Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	Version 1	13 April 2006
Investigator CV	Version 1	12 April 2006
Protocol	Version 1	12 April 2006
Covering Letter	Version 1	12 April 2006
Peer Review	Version 1	28 March 2006
Interview Schedules/Topic Guides	Version 1	12 April 2006
Letter of invitation to participant	Version 1	12 April 2006
Participant Information Sheet	Version 1 (with reply slip)	12 April 2006
Participant Information Sheet	Parent/Carer Version 1	12 April 2006
Participant Consent Form	Parent/Carer Version 1	12 April 2006
Participant Consent Form	Version 1	
Supervisor CV	Dr N.Robertson	12 April 2006
Flow Chart	Version 1	12 April 2006
Supervisor CV	A.Tweed Version 1	12 April 2006

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Appendix 5

Leicestershire Partnership **NHS**

NHS Trust

Research & Development Office
Daisy Peake Building
Towers Hospital
Gipsy Lane
Leicester
Tel: 0116-225-3743
Fax: 0116-246-3591
David.Clarke@leicspart.nhs.uk

01 August 2006

DC/KJC/Q2502-44

Ms Karen J Caesar
Trainee Clinical Psychologist
C/o University of Leicester
104 Regent Road
Leicester
Leicestershire

Dear Karen

**Re: A Qualitative Analysis of Service Users' Experiences of Attending
Ward Rounds
Trust Ref: CHAF0414**

Thank you for the copy of correspondence from the Leicestershire Local Research Ethics Committee (Two), confirming that following the submission of your amended documentation the project has received formal ethical approval.

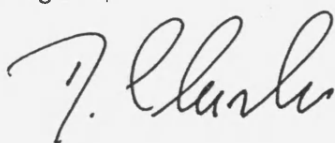
Under the Research Governance Policy of the Trust, confirmation of appropriate ethical approval is a necessary prerequisite for obtaining Trust Management Approval. I am happy to confirm therefore that as Co-Sponsor of this research, Leicestershire Partnership NHS Trust formally approves the study to proceed, subject to the following conditions:

- You abide by the conditions imposed by the REC
- All correspondence with the REC is routed through the Trust Research Office (including the obligatory progress/final report as detailed).
- The agreed protocol is adhered to.
- A summary of any findings is reported to the Trust/Clinical Service/Participants at the conclusion of the study.
- Any changes in the protocol, timescale etc. are notified to the R&D Office
- At the conclusion of the study, a final report form is completed.
- A copy of any subsequent publication is lodged with the Trust.
- That paperwork related to the study may be subject to audit at any time (this requires maintenance of a site file).

This letter also serves as confirmation that as Principal Investigator you are covered by the terms of the Trust's research indemnity for the duration of the project.

Please sign and return the attached confirmation. With best wishes on the success of your study.

Regards,



Dr. Dave Clarke
Associate Director (R&D)

Appendix 6



**University of
Leicester**

**School of Psychology
Doctorate in Clinical Psychology**

104 Regent Road
Leicester LE1 7LT · UK
Tel: +44 (0)116 223 1639
Fax: +44 (0)116 223 1650

**Re: Participation in a Research Study:
Service Users' Experiences of Attending Ward Rounds**

I am currently planning a research study, at the University of Leicester, as part of my professional training to become a clinical psychologist. This study is to be carried out with the support of [REDACTED]. You are being invited to take part because you are currently, or have in the past, been involved with [REDACTED]. I would be very interested indeed to talk to you about your experiences of the ward rounds you attended. The results of this study will hopefully provide both staff and service users with an insight into the ward round experience and will highlight what factors are important in making this as positive an experience as possible.

If you are interested in taking part or would like to find out more about the study, please read the enclosed Information Sheet. This gives you more details about the study and explains what taking part would involve. If after reading the Information Sheet you are still interested, please complete the reply slip attached, returning it to me in the enclosed pre-paid envelope. As you will see, there is a chance for you to meet with me to ask any questions before deciding whether or not to take part.

I would like to thank you for taking the time to read this letter and I hope to hear from you soon. If you have any questions, please do not hesitate to contact me by one of the methods given below. If you call me I will call you back if that helps. Alternatively you can talk to either [REDACTED] or [REDACTED] at [REDACTED] who have details about the study.

Yours sincerely

Karen Ceaser
Trainee Clinical Psychologist
Centre for Applied Psychology, Clinical Section, University of Leicester.

Appendix 7



**University of
Leicester**

**School of Psychology
Doctorate in Clinical Psychology**

104 Regent Road
Leicester LE1 7LT · UK
Tel: +44 (0)116 223 1639
Fax: +44 (0)116 223 1650

Can You Help With My Research

A project to look at how you feel about ward rounds?

Lots of people attend ward rounds as part of their treatment and care. I want to find out what it was like for you when you have been to a ward round. This is your chance to tell your story about what it felt like! So, if you are: over 14 AND have ever been to a ward round I would really like to talk to you.

Who is doing the research?

My name is KAREN CEASER and I am from the UNIVERSITY OF LEICESTER. If you decide to take part in the research I will be the person who interviews you. If you would like to take part I can come and see you so that you can ask any questions or discuss any concerns you might have about taking part. If after we have talked about this you decide to take part we can arrange a day and time for the interview.

I want to hear your story

I think it is really important to hear your story because I want to understand what it feels like for **YOU** to attend a ward round. By sharing your story with me, I hope it will help me to understand both good and bad experiences you may have had and increase people's awareness of a very important part of the care you receive.

What will you have to do?

I would like you to take part in one interview, you can either do this just with me or if your parents are willing, they can be there too. It's up to you! The interview will last for about 1 hour. You can choose where you want to be interviewed but ideally it will be relatively quiet. This could be at your home or I can book a room at xxx, wherever is best!

Do your parents/carers need to know if you want to take part?

If you are under 16 years old, you will have to tell your parent/carers that you would like to take part in this research. After talking about this with them, if they think it would be a good idea that's great! If you are over 16 you do not need to get your parents consent, but you may decide you want to tell them about it anyway. Your parents/carers may also have been asked to take part and you can either be interviewed with them or separately, whichever you chose!

What is Consent?

Consent means agreeing to take part in this research project. If you decide you would like to, then you, your parents (if you are under 16) and me (Karen Ceaser) will sign a "consent form" **BUT** you can still change your mind at any point. This means that should you decide at anytime you no longer want to take part that is fine. Whether you decide to take part or not, this will not affect your treatment, care or contact with ~~the research team~~ at any point now or in the future. If you would like to meet with me to talk about taking part this can be arranged. You can either decide at that meeting if you want to take part, and we would then arrange a day for the interview, or if you needed more time to think about it you can ring me within a month to let me know if you would like to take part.

What will happen to what you say?

If you agree to take part, what you say in the interview will be tape recorded. It will then be typed out and saved on a computer disc. When it is typed out, your name will be changed to make sure that everything you have said is "confidential". This means that nobody will find out your personal details or what you have said. The only time that confidentiality would be broken is if I was worried that you or someone else was at risk. The Clinical Psychologist at ~~the research team~~ has said that they will follow up any concerns should this happen to make sure everyone has appropriate support available. If confidentiality was going to be broken I would talk to you about this and explain it in detail before doing so.

What happens when the research is finished?

When the research is finished, if you want, I will write to you to let you know what I have found. Your parents will also have the choice to receive a copy of my findings. This will involve sending a written summary of what people have said. Remember though, that because all names will be changed, nobody reading the report will know who has said what. Based on what you, and others who chose to take part have said, it will hopefully help the staff at ~~the research team~~ think about ways in which any areas of the ward round you may not be happy with can be changed.

What happens if you become upset?

If you become upset during the interview you can ask me to either take a break to stop the interview altogether. If you feel upset after the interview or when I leave you can talk to the Clinical Psychologist to get some extra support.

Withdrawing from the research

You can withdraw from the research at any point, even after you have given written consent. Any information collected from you at that point would then be removed from the study.

If you are interested in taking part

1. If you are under 16, show this sheet to your parent/carers and talk about it with them.
2. Fill in the information on the next page and send it back in the envelope provided. I will then contact you to arrange a meeting so we can discuss this further and I can answer any questions you may have.

Thank you very much for taking the time to read this.

A Project to Look at Your Experiences of Ward Rounds

Date: _____

My Name is: _____ Age: _____

My Address is: _____

Tel No _____

Please circle Your Response:

I **HAVE** talked about this with my parents

YES / NO

I **AM OVER 16**

YES / NO

I would like to take part in an **INTERVIEW**

YES / NO

I would like to **MEET WITH THE RESEARCHER** to
discuss this in more detail

YES / NO

Please **CONTACT ME** to arrange this by

LETTER / PHONE

Please write down any questions or worries you have about taking part.
This will help me to prepare for when I come and meet with you:

Appendix 8



**University of
Leicester**

**School of Psychology
Doctorate in Clinical Psychology**

104 Regent Road
Leicester LE1 7LT · UK
Tel: +44 (0)116 223 1639
Fax: +44 (0)116 223 1650

INFORMATION SHEET FOR PARENTS/CARERS

A Project to Look at Your Experiences of Ward Rounds

What is this project about?

This project is about finding out what the experience of being at a ward round has been like for both the young people and their parents/carers who have attended them.

Who is doing the research?

My name is KAREN CEASER and I am from the UNIVERSITY OF LEICESTER. If you decide to take part in the research I will be the person who interviews you. If you would like to take part I can come and see you so that you can ask any questions or discuss any concerns you might have about taking part. If after talking this through you decide you would like to take part we will then arrange a date, time and location to do the interview.

Why I want to hear your story?

It is well documented that ward rounds can be a stressful time for people who attend them. However, it has also been reported that some people find them to be a helpful and productive experience. If you have attended a ward round as part of your son or daughter's care, or as the carer of someone at XXXX, I would like to hear what this experience was like.

Encouraging your child to tell their story

It is important to continue gaining the views of the people who use services within the NHS and this includes parents, carers and their children. It may be that your son/daughter has had a different experience to yourself at the ward rounds, or they may have had a similar experience. It is important to understand how the ward round is viewed by all service users and to find out what issues are of most importance to parents and their children.

What will the project involve?

If you decide to take part you will be asked to take part in one individual interview that will last anything from 20 to 90 minutes (depending on how much you have to say!). If your son/daughter wants to take part they will also be interviewed for the same time. You would be interviewed separately unless you all preferred to be interviewed together. It is hoped that 10-12 people will be interviewed altogether and that this will consist of parents carers and children. In order to get a wide range of views ideally both boys and girls, and Mum's and Dad's will be interviewed. Only one parent can be interviewed if this is preferred or is more convenient. It does not matter if you have been to 1 or 100 ward rounds I would still like to hear about your experience!

What sort of questions will be asked?

The questions in the interview will ask how attending the ward round feels. For example, how it felt being there, if you felt able to ask questions, your feelings on how many staff were present. The interview is interested in the experience of ward rounds only and no questions will be asked about other aspects of contact/treatment with the service. Whilst the experience of each person attending may be different, the aim of this research is to identify any common themes or issues that emerge that appear to be important to both parents and children that attend ward rounds.

Where will the interview take place?

The interviews can take place wherever is most convenient for you but ideally this will be somewhere what is free from distraction. For example, this could be either at your home, or I can book a room at ~~the hospital~~ or the University. You do not have to be interviewed in the same location as your son/daughter if they are also taking part but if that is your preference that is no problem. If you have decided to be interviewed at the same location I can either do both interviews the same day or different days.

What will happen with the information?

All the information will be confidential. Each interview will be audio taped to aid the interviewer to remember all that participants have said. Each interview will be transcribed, (typed out word for word). During transcription all information will be changed to ensure anonymity of participants. All tapes and transcripts will be kept in a secure location and all information held on computers will be password protected. Access to data will be restricted to the interviewer and supervisors of the project at the University.

Consent for you and consent for your child

For each person who would like to take part, they will be asked to sign a consent form. This is a written agreement to record that they understand what the project is about and that they would like to take part. If you are interested in taking part you will be given a chance to meet with the researcher to ask questions you may have. If you need more time to think about participating after the meeting you can contact me within a month to let me know your decision. Your son/daughter may have also been sent an information sheet explaining what this study is about. If they are aged 16 or over they are able to consent to take part themselves. If they are under 16 and want to take part, you will need to sign their consent form too.

What happens if you or your child becomes upset after the interview?

It is important to plan for every eventuality. If you or your child becomes upset after the interview you will be given a chance to talk with the researcher about this. If you would prefer to talk to someone within the service, the Clinical Psychologist there has agreed to be available to talk about this with anyone who feels the need to.

Withdrawing from the research

You can withdraw from the research at any point, even after you have consent or have been interviewed. Any information at that point would then be destroyed. Whether you agree to take part or not this will not affect the care, treatment or contact you and your child have with the service at any point now or in the future.

Will you get to see a copy of the findings?

Once everyone has been interviewed, the research will be written up and a summary of the findings can be sent to any participants that would like to receive them. The specific comments made during the interviews will be anonymised and will not be fed back to anyone as an overall summary will be sent. A summary report will also be sent to the research team as it is important that staff are made aware of any concerns you have, and equally of any positive comments about the ward rounds, but again your comments will all be anonymised.

THANK YOU FOR TAKING THE TIME TO READ THIS

A Project to Look at Your Experiences of Ward Rounds

Date: _____

My Name is: _____

My Address is: _____

Tel No _____

Please circle your response:

I am a: Parent/Carer

Of a: Current Resident/Former Resident

I would: Like to be Interviewed/Meet to discuss it further/Not like to take part

Contact me by: Telephone/Letter

Please write down any questions or worries you have about taking part. This will help me to prepare for when I come and meet with you:

Appendix 9

CONSENT FORM FOR YOUNG PEOPLE

A Project to Look at Your Experience of Attending Ward Rounds

Researcher: Karen Ceaser, Trainee Clinical Psychologist

Based at: School of Psychology, Clinical Section, University of Leicester,
104 Regent Road, Leicester, Leicestershire, LE1 7LT.

I have read the Information Sheet about this project.

☐

I have met with Karen Ceaser who has explained the project to me. I have had the opportunity to ask questions and understand what I will be required to do.

☐

I understand that the interview will be tape recorded and that the tape will be kept in a safe and secure place and the information I give will be used for this project only.

☐

I understand that the information I give will be treated as confidential unless the researcher becomes concerned someone is at risk.

☐

I understand that I can change my mind and pull out of the project at any time if I want to. If I do, any information I have given will be withdrawn from the study.

☐

I understand under that taking part in the research will not affect me contact/care at ~~the hospital~~ at any point now or in the future,

☐☐

I AGREE TO TAKE PART IN THIS PROJECT

☐

I confirm that I have explained the nature of this study, detailed in the Information Sheet, in terms which, in my judgement the participant has understood.

Name of Participant

Signature of Participant

Date

Name of Parent (if you are under 16)

Signature of Parent

Date

Name of Researcher

Signature of Researcher

Date

CONSENT FORM

Project to Look at How You Feel About Ward Rounds

Appendix 10

I have read the Information Sheet about this project.

I have spoken with Korea Cancer, the interviewer. The project has been explained to me, I have had the opportunity to ask questions, and I understand what I will be required to do.

I understand that the interview will be audio-taped, in a room that will be locked and secure, and the information I give will be used for this study.

I understand that the information I give will be treated as confidential, and that it will be stored securely, and that I will be able to withdraw from the project at any time without any penalty. The information I have given will be well clear from the study.

I understand that I will be asked to sign this form.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

I have read this form and I have signed it.

CONSENT FORM

A Project to Look at How You Feel About Ward Rounds

Interviewer: Karen Ceaser

Based at: School of Psychology, Clinical Section,
University of Leicester, 104 Regent Road, Leicester, LE1 7LT

I have read the Information Sheet about this project.

I have met with Karen Ceaser, the interviewer. The project has been explained to me, I have had the opportunity to ask questions, and I understand what I will be required to do.

I understand that the interview will be audio-taped. I understand that the tape will be kept in a safe and secure place and the information I give will be used for this project only.

I understand that the information I give will be treated as confidential. I understand that I can change my mind and pull out of the project at any time if I want to. If I do, any information I have given will be withdrawn from the study.

I AGREE TO TAKE PART IN THIS PROJECT

1. Signature of participant _____ DATE _____

Name in BLOCK CAPITALS _____

I confirm that I have explained the nature of this study, as detailed in the Information Sheet, in terms which, in my judgement are suited to the understanding of the participant.

2. Signature of researcher _____ Date _____

Name in BLOCK CAPITALS _____

Appendix 11

Service Users' Experiences of Attending Ward Rounds: An Explorative Study

Introduction

- Background to the research, reminder of confidentiality & anonymity, that it won't affect contact/care with service, explain format of interview, obtain written consent.

Background

- How long they/their son or daughter had contact with the service?
- How many ward rounds have they been to (estimate if don't know)

Questions about Experiences of Ward Rounds

- How would you describe a ward round to someone who didn't know what one was?
- Did you have any expectations about WR before you first attended, what were they? (hopes/fears)
- Did your experiences of WR match with your expectations?
- **How did you feel when you first heard you had to attend a WR?**
- **How did you feel before you went to your first WR?**
- **And how did you feel before you went to the most recent WR?**
- Did your actual experiences of WR's match with your expectations?
- How would you describe the atmosphere of the ward round?
- What have been your negative and positive experiences at a WR and what made the difference?
- Were you given a choice in attending? If so did you consider not doing? Is it a real choice?
- If ever had any difficulties during WR's what were they and how did they make you feel?
- What was helpful and what was unhelpful in your experience of WR's?
- Did you feel able to contribute at WR's? If so what helped? If not what would have made it easier?
- **Do you think its possible for other people to understand what WR are like for you? If so, who?**
- **What do you think the impact of attending WR's was on you? (practical, emotional, behavioral)**
- **Have your views on WR changed over time , if so how? Do you feel you have adapted to them?**
- If you could make changes to WR's what would they be and why?
- Finally, is there anything else you would like to tell me about your experiences of WR's.

Debriefing

Thank for taking part and say how much it is appreciated to hear views about WR's.

Appendix 12

Service Users' Experiences of Attending Ward Rounds: An Explorative Study (revised interview guide)

Introduction

- Background to the research, reminder of confidentiality & anonymity, that it won't affect contact/care with service, explain format of interview, obtain written consent.

Background

- How long they/their son or daughter had contact with the service?
- How many ward rounds have they been to (estimate if don't know)

Questions about Experiences of Ward Rounds

- How would you describe a ward round to someone who didn't know what one was?
- Did you have any expectations about WR before you first attended, what were they? (hopes/fears)
- Did your experiences of WR match with your expectations?
- How did you feel when you first heard you had to attend a WR?
- Did your actual experiences of WR's match with your expectations?
- How would you describe the atmosphere of the ward round?
- What have been your negative and positive experiences at a WR and what made the difference?
- Were you given a choice in attending? If so did you consider not doing? Is it a real choice? (focus on this)
- If ever had any difficulties during WR's what were they and how did they make you feel?
- What was helpful and what was unhelpful in your experience of WR's?
- Did you feel able to contribute at WR's? If so what helped? If not what would have made it easier?
- **Do you think its possible for other people to understand what WR are like for you? If so, who?**
- **What do you think the impact of attending WR's was on you? (over time, whilst still here)**
- **Have your views on WR changed over time , if so how? Do you feel you have adapted to them?**
- If you could make changes to WR's what would they be and why?
- Do you think it makes a difference that you are a current resident, does that effect your experiences at all?
- **Gender and support with residents?**

Debriefing

Thank for taking part and say how much it is appreciated to hear views about WR's.

Do you have any questions you would like to ask about the interview?

Appendix 13

- KC 14 Okay, thanks, can you expand on that a bit more please, what happens?
- Dougie 15 Oh yeah, sorry. The staff tend to talk about like what's happened in that week.
describing WR, reviewing week
- 16 So, like it I had missed school that would get brought up for sure. And if my
feeling 'bad things' brought up
- 17 Meds had changed then that would get a mention to! They also talk about how
practical aspects of WR (changes to meds)
- 18 you (me that is) interacts in the Unit really, how your getting on with people.
being talked about - interaction & care's discussed
- 19 And that sort of thing. It would depend on if I had behaved as to what was
behaving (or not) behaviour determining context
- 20 brought up. In fact, [laughs], when I had been good they didn't say much!
feeling good behaviour not acknowledged
- 21 I'm not really sure what my parents got out of it, they came with me. Never,
considering parents exp's - unaware of it
- 22 I don't remember them saying much but I think they just wanted to know how
parents not discussing WR much
- 23 I was getting on and didn't maybe trust I would tell them the truth!
parents showing an interest - feeling disbelieved / untrusted by parents
- 24 So for them maybe they just saw it as the chance to get updated about how
considering parents news - chance to get updated
- 25 I was getting on I suppose. They never really said much though, not to me.
& progress not sharing exp's & him.
- KC 26 Ok. I wonder, did that bother you, that they didn't talk to you direct?

Appendix 14

Supporting Quotes to Justify Category Names

ADAPTATION

"..despite their bad points, I guess I realise now they need to exist and it feels kind of weird that I just got used to them really. I guess with time you just adapt accordingly, make the necessary adaptations, I did"

Danni, young person, Line 211

"I think, god forbid we ended up attending another twenty we would get more used to them. I suppose the other thing is that as time goes by you just get used to them, you adapt"

Meg, parent Line 220

NEGATIVE EXPECTATIONS FOR YOUNG PEOPLE

"I just decided that I expected to feel nervous and I would not like them"

Joanna, young person, Line 20

"But then I guess I kinda expected them to make me feel awkward even if they may help. I expected not to like it in there really"

Tom, young person, Line 55

ATTENDANCE AS FORCED CHOICE

"I didn't feel I had a choice about going to the ward rounds then, looking back now I can see how the way it is explained makes you feel you have to go".

Danni, young person, Line 164

"and I guess to some extent I didn't really feel I had much of a choice anyway, felt the answers to my questions were practically held hostage there"

Suzie, Parent, Line 57

RAISING HOPES FOR PARENTS

"we didn't know what was happening so when we heard that a ward round would be held each week I think it was a relief, we felt that everyone would be there and we would be able to get some answers at long last"

Meg, Parent, Line 10

"second to be fair. I suppose at the end of the day my informed knowledge did not help and I was in the same boat as all of the others. I had to go to know. I needed to go to know what to expect so I was more hopeful about them weirdly."

Charlie, parent, Line 78

INCREASING ANXIETY

"I think, they mentioned it on the induction day. But just in passing like. I didn't really know what one was to be fair, not knowing got me quite anxious about what would happen, I just got more worried really I guess".

Tom, young person, Line 23

"But in a way knowing that was the place to get all the answers made us more anxious, cos it was like, we really need this, it has to work, that led to increased anxiety about just how big the rounds would be".

Ben, parent, Line 18

FEELING UNDER THE SPOTLIGHT

"I think I just, my impressions are ones of feeling judged and watched, on show too".

Danni, young person, Line 207

"When I first walked in I was shocked, yeah, it was a room full of them. It felt like I was on stage really I suppose. Bit of a shock and that made".

Suzie, parent, Line 31

ACTIVE AVOIDANCE

"I don't know if I explained that too well sorry. I think there is something about like, it forces you to sit and think about stuff I chose to avoid otherwise?"

Jordan, young person, Line 109

"And some things you just can't change anyway, like the way in which all the things you don't really want to think about are shoved in your face at ward rounds."

Meg, parent, Line 181

INTENSIFYING EMOTIONS

"It was good if I had made progress and I felt I had achieved something, its like I felt proud anyway but hearing the staff say I should be proud like gave me permission to and made me feel even prouder and happier"

Tom, young person, Line 152

"I think the word is intense. The way I feel gets intensified in there. So far that has been a mixture of good and bad".

Meg, parent, Line 161

FEELING JUDGED

"It's difficult to say its, just felt everyone was judging me, and that would have been more been a bit more bearable if there were just like four or five there. But to feel judged in front of an audience of ten or more, that was hard you know."

Jordan, young person, Line 138.

"I think they did judge our parenting abilities e a bit maybe they are bound to she was an inpatient!"

Harry, parent, Line 213

BECOMING PART OF THE ROUTINE

"The thing with ward rounds is though, they happen so often they get to be part of your routine and when that happens, I guess the things that happen in them are routine too."

Dougie, young person, Line 257

"I took the morning off work just cos they do them on a morning. I guess I felt I had to fit it into my life cos there was no room to fit my life into them."

Harry, parent, Line 313

ADAPTING BEHAVIOURS

"It made me see that, doing okay does not really make you a geek or anything and I suppose in a way it made me grow up. I had changed my behaviour when I went in, then changed it back."

Dougie, young person, Line 287

"I recall being intrigued but how I sort of adapted my behaviour to suit them I mean, things like, I even dressed as if I was going for an interview, and I tried to hide my accent when I spoke. Trying to be someone I not, didn't last long mind!"

Suzie, parent, Line 215

IMPORTANCE OF SHARED UNDERSTANDING

"I think what really makes the difference is if you are the one being talked about, if you are the patient rather than the staff member or the parent. It is hard to see how you can understand fully what it feels like to sit there and be the one at the centre of it all – only other inpatients know and understand that"

Joanna, young person, Line 96

"But the wife and I, we have a shared understanding of the ward rounds difficulties for us as parents".

Harry, parent, Line 333

WANTING TO BE HEARD

"I was often scared to offer my opinion in the ward rounds. I did once have the guts to speak up about a really important matter and it was met with like, okay thanks for that and then went onto the next subject! I was mortified, I spoke up about a really important issue and they just didn't seem to want to know"

Jordan, young person, Line 124

"No other than ideally, I would be heard as well as my daughter, I have to be heard."

Charlie, parent, Line 86.

SEEKING INFORMATION

"Sometimes it is really hard. The thing is I really need to be able to get some answers, the information to help me, I look for it there."

Joanna, young person, Line 77

"Yes I was happy to attend, and see staff and to be able to get some information and to ask some questions."

Ben, parent, Line 15

FEELING SUPPORTED

"I made some good friends there, I'm sure supporting each other was part of that."

Joanna, young person, Line 102

"So I would always go to him as my main support and that really works. It is a tough time but I think we both feel we are supported, by each other."

Meg, parent, Line 210

CONSIDERING REASONS BEHIND CHANGE

"Umm. Well I feel different now than then cos I am better, that has made my views change a bit, feeling better makes them seem like they were okay."

Joanna, young person, Line 147

"Yes now I see the ward rounds changed, but that was cos everyone was so nice there in the end, made me see that they were just there to help and not to judge really."

Harry, parent, Line 231

RECOGNISING THE POSITIVES

"Like I said I can see more positives now and the negatives you just have to get on with em really cos they won't go away just cos you do not like them"

Joanna, young person, Line 73

**** Theme not fully saturated, emerging later on in data collection.**

LIVING WITH THE NEGATIVES

"Just that there were lot's of negatives I guess but focusing on them didn't help. I needed to just accept them and focus on the good stuff so the bad stuff didn't get in the way. Live with the negatives, focus on the positives".

Jordan, young person, Line 343

**** Theme not fully saturated, emerging later on in data collection.**

DEVELOPING NEW EXPECTATIONS

"But already with the things I have experienced, that experience informs my expectations and I guess I kind of revise my initial ones, make new ones, more realistic ones."

Tom, young person, Line 173

"Because, when I was at the first I had expected them to be okay. Then I realised that they would be less annoying if I accepted my initial expectations were inaccurate, and construct some new ones to approach new rounds with."

Charlie, parent, Line 159

FURTHER CONSOLIDATION OF EXPERIENCES

"Have my views changed? I don't know, ask me in a year and I may still be thinking about them. It's not that I don't want to move on but I guess now I am away from that place I can think about it in a more objective way."

Dougie, young person, Line 307

Appendix 15

Appendix 15

Participants' Ward Round Attendance Details

Participant Name	Current/ Former Resident	Young Person/ Parent	WRs Attended	Length of Admission	Time between attending WR and interview
Danni	Former	Young person	100+	36 months	24 weeks
Jordan	Former	Young person	12	6 months	4 weeks
Suzie	Former	Parent	24	6 months	7 weeks
Harry	Former	Parent	50	12 months	12 weeks
Dougie	Former	Young person	13	4 months	5 weeks
Tom	Current	Young person	4	Current	3 days
Charlie	Current	Parent	8	Current	5 days
Joanna	Current	Young person	4	Current	1 day
Ben/Meg	Current	Parents	4	Current	1 day