

TALKING WITH ACUTELY PSYCHOTIC PEOPLE

**Communication skills for nurses
and others spending time
with people who are very mentally ill**

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DEDICATION

This work is dedicated to our 28 interviewees, on whose expertise it is based, and to all those engaged in caring for the acutely mentally ill

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PREFACE

You, talking to me?!

As often, when faced with new ideas, novel theories or revolutionary concepts, the first thought is, "Surely this has been done before – and if not, why not?"

Many of the work practices evolved by the 28 expert nurses in this study seem obvious, but it is clear that the reality on many – or most – psychiatric wards is one of non-communication and mutual incomprehension.

This research, when translated into a 'guide' or 'handbook' for nurses, should provide a very useful if not essential part of their education.

The way that expert nurses dealt with - or rather related with - patients seemed to lead to better outcomes for the patients and for the nurses. So, if we could promote the nursing practices described in this work it is likely to lead to improved outcomes for service users and much happier staff.

Strikingly, many of the nurses did not describe just using language but spoke of a range of different mediums, including non-verbal communication and, most excitingly, other more creative methods.

Students and staff should not only read this but be actively encouraged to feedback (anonymously if they prefer) how they get on putting these principles into practice but also to identify the factors that prevent or make it difficult for them to do so. This will enable dialogue and learning to continue.

For many of us, this reminded us that there had often been that special nurse, that one person, that "somebody who was there for me"; someone who did do it and did put it into practice.

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INPATIENT NURSING CARE AND INTERACTION

Acutely mentally ill people present their conversational partners with a perplexing range of behaviours and challenges to normal social interaction. Their mood might be one of euphoria and elation, with thoughts running through their head at speed, skipping from topic to topic as a spun stone skips over water. Or they might be deeply depressed, full of thoughts of guilt and painful emotions, with both speech and movement considerably slowed. Alternatively all their emotions might be flattened, dampened, unresponsive or incongruous. They might be obsessed with strange ideas and interpretations of the world and what is going on around them, with these beliefs often about a hostile world. Coupled with these delusional beliefs may be auditory or other hallucinations, commenting on what is going on around them, instructing, abusing, or generally interfering with their ability to think. In addition to the distraction caused by hallucinations, their thinking processes and verbal abilities might also be directly affected by a variety of thought disorders. They may be irritable, incongruous, unpredictable, and perilous conversational partners until their illness stabilises.

Some people experience only one acute episode of the conditions currently called schizophrenia and manic depressive psychosis, which then gratifyingly resolves over time and never recurs. Others experience periods of wellness in between relapses and recurrences, whereas yet others have the conditions chronically with continuous symptoms, and experience exacerbations on top of this. All such people generally receive help, care and support largely in the community. However during periods of acute illness, when they are at higher risk of coming to harm, harming themselves, or possibly harming others, when they have little in the way of social support, when they live in a rejecting and stigmatising community, they are likely to be admitted temporarily to an acute psychiatric ward (Bowers et al. 2009). A proportion of these admissions are compulsory using mental health legislation. Such admissions are most likely to last about three weeks in the UK, and allow their condition to be assessed, appropriate treatment given, their physical healthcare and daily living needs to be attended to, and their safety maintained (Bowers 2005). Although psychiatrists regularly visit and see patients, and occupational therapists provide structured activities, most of the 24 hour care for patients is provided by a mix of qualified and unqualified nursing staff. However advice and information is scarce on how nurses should interact with acutely psychotic patients so as to effectively keep them safe, assess their needs, deliver treatment and provide physical healthcare. In the following sections we review the recent development and history of inpatient care in order to pull together what information exists.

Nurse-patient interaction

Over the past fifty years there have been a number of research studies about nurse-patient interaction on acute psychiatric wards, coupled with theoretical work about the nature of psychiatric nursing derived from neo-Freudianism. On the plus side, the work of the nurses is generally highly regarded by patients (Rogers, Pilgrim, & Lacey 1993), and nurses can relate many critical incidents where their interaction with patients has been highly valuable (Cormack 1983; Flanagan & Clarke 2003). The nurse-patient relationship is generally seen as central to the provision of good inpatient care, and the widespread acceptance of this is generally due to the work of Hildegard Peplau (Peplau 1991). However there have also been several reports of low levels of actual nurse-patient interaction, with 8% of nursing time spent in interaction with patients

(Altschul 1972), 15% (Sandford, Elzinga, & Iversen 1990), 19% (Tyson, Lambert, & Beattie 1995), 21% (Sanson-Fisher, Poole, & Thompson 1979), 7% of nurses' time in potentially therapeutic interaction (Whittington & McLaughlin 2000), and patients spending only 4% (Hurst, Wistow, & Higgins 2004) or 6% (Martin 1992) of their time in interaction with nurses. One of these studies showed that as staffing numbers increased, staff-staff but not staff-patient interaction increased (Sandford, Elzinga, & Iversen 1990). These figures are quite variable, indicating that some places at some times have up to three times as much nurse-patient interaction as others, nevertheless nursing has generally been intensely criticised for low levels of interaction. This has resulted in a low valuation of the time consuming and complicated case management work also carried out by ward staff which does not involve direct nurse-patient interaction (Deacon 2003). Another effect of this critique has been a concentration on interpersonal skills during nurse training, exercises to improve communication (Star Wards 2009) and more lately, centralised audits and policies that require a documented minimum of 15 minutes one to one nurse patient interaction for every patient during the course of a nursing shift (Healthcare Commission 2008).

Interpersonal and communication skills

Curriculum changes in psychiatric nurse education in the 1980s gave much greater emphasis to training in interpersonal skills. These advances were swiftly overtaken by further nursing education changes (Project 2000) during which nurse education in the UK was brought into the University sector and the first half of training became a common foundation programme (CFP) for all nursing specialities (i.e. psychiatric nursing combined with general nursing, children's nursing etc.). Whilst this new model brought greater academic breadth and rigor to nurse training, it also adversely impacted on intense, small group interpersonal skill development in psychiatric nurse training.

The interpersonal skills which are taught to nurses are based on social psychology research into communication and social skills (Hargie 2006) merged with ideas from counselling psychology and the psychotherapies (Egan 2002; Heron 2001; Rogers 1961). These skills are not specific to mental illness or psychotic disorder, instead including generic listening skills (eye contact, body orientation, attention, prompts, use of open questions, reflection, paraphrasing, summarising, probing, demonstrating empathy, etc.), coupled with basic problem identification and solving approaches. Since the 1990s many psychiatric nurses have additionally been trained in de-escalation as part of courses in the prevention and management of violence and aggression (Lee et al. 2001; Wright 2003). De-escalation skills are generally poorly defined, but include (Stevenson 1991): non threatening postures, calm and quiet tone of voice, careful use of interpersonal space, mirroring, open questions, etc. These interpersonal skill areas clearly overlap, and although both are applicable to acutely psychotic patients, neither is specifically elaborated in any way for its application to patients who are in such a condition or state.

The nursing process, Isobel Menzies-Lyth, and primary nursing

By the 1970s and 80s, traditional psychiatric nursing care was perceived to be overly custodial, unsystematic and task oriented. These concerns were shared in the general nursing field, where there was similar dissatisfaction. In psychiatric nursing this discontent was fuelled by a psychoanalytic study and interpretation of general nursing working styles by Isabel Menzies-Lyth of the Tavistock Institute (Menzies 1960). So powerful was this analysis that it remains regularly quoted to the current day, and is still well read by psychiatric nurse educators, often circulated as multiple generation, faded, difficult to read photocopies. The essence of that analysis was that task allocation, the system by which nursing care activities were shared out during a shift of work, was a social defence against anxiety. Task allocation was the giving of fixed

tasks to individual nurses, such as doing the observations, medication, baths, dressings, meals, etc. Such an allocation of work meant that care for the individual patient was fragmented, as their needs would be met by many different nurses during the course of the shift. Menzies-Lyth argued that such fragmentation was unconsciously motivated to prevent meaningful relationships between nurses and patients, and thus defend nurses from the anxiety provoked by dealing with pain, deformity, death and dying. Psychiatric nurses read this as equally true in relation to acute inpatient care, the anxiety in this case being provoked by the psychic pain and fragmentation of the acutely mentally ill person.

This concern and awareness converged with new developments in the organisation of nursing care in the US: nursing models, the nursing process and primary nursing. The order in which these arrived in the UK, and their penetration of psychiatric nursing practice, has varied over time and across the country. However it would be fair to say that the nursing process was the first and most influential of these developments. It was a method of nursing work that sought to systematise and improve practice through the implementation of a cyclical process of assessment of patients' needs, planning care, implementing that care, and evaluating it. Early nursing research in the UK did demonstrate that when the nursing process was implemented, the quality and continuity of care improved. It was eventually universally used in nursing, forming part of the move towards individualised care (McFarlane & Castledine 1982). The nursing process continues in use today, shaping the documentation and practice of in-patient psychiatric nursing, although the degree to which it has been successful, or as successful as it could be, remains open to question. Amongst community psychiatric nurses, the nursing process has been subsumed within the care programme approach, which is a multidisciplinary commitment to a shared care plan.

Nursing models (Meleis 1985) flowed out of a pre-occupation with trying to define what nursing was, and what made it distinct from the activities of other healthcare occupations. Such theorising was associated with the move of nursing education into the University sector and the initiation of degree and higher level degree courses in nursing, coupled with aspirations towards a higher professional status. A multitude of such nursing models were produced, nearly all of which were based upon general nursing practice, with the intention that such models could shape nursing curricula as well as the practice of nursing – particularly the assessments and care plans being formulated through the use of the nursing process. Some of these models, particularly that of Peplau previously mentioned, were imported and applied to psychiatric nursing in the UK, again emphasising the interpersonal nature of psychiatric nursing and individualised care. Models reached the height of their influence in the 1980s, but are now mostly absent from both education and the practice of mental health nurses in the UK, with the exception of the Tidal Model which will be discussed further below. It has been argued elsewhere that any such models have to start from what psychiatric nurses actually do and contribute to acute inpatient care if they are to remain influential, rather than seek to arbitrarily redefine nursing work as something else (Bowers 2005).

Primary Nursing was the last of the great US nursing innovations to jump the Atlantic. Associated with the name of Marie Manthey (Manthey 1980), primary nursing was a way of organising the nursing team across shifts so that one qualified nurse was always in charge of the care of a fixed number of patients, whether the nurse was present or not. That nurse carried out the nursing assessment, drew up the nursing care plan, reviewed and evaluated that care, and was responsible for interdisciplinary liaison and communication with the patient's family. When the primary nurse was not on duty, other nurses (who were primary nurses for other patients) acted as associate nurses and delivered the care as prescribed by the primary nurse. This organisation gave the primary nurses considerable autonomy and responsibility, and again enhanced individualised care and strengthened the nurse-patient relationship. Only a small number of wards in psychiatry made a thorough implementation of primary nursing (Bowers 1987; Bowers 1989; Ritter 1985), but reports were generally positive. Before any more widespread implementation could occur, the UK government

mandated that every patient should have a 'named nurse' (Department of Health 1991). Such allocations were carried out and remain so today, however the specific responsibilities of the 'named nurse' were not defined by policy, thus the role became titular and the opportunities presented by primary nursing proper were lost.

Sadly, none of these three innovations was specifically elaborated for how individualised care was to be delivered to acutely psychotic patients, or how a nurse-patient relationship was to be built up across the divide of cognitive deterioration, suspicion, delusional beliefs and sometime coercive treatment. So although they thrust nurses into such relationships, they were left to devise on an *ad hoc*, learn by experience basis, how to actually do it.

Outside the mainstream: Laing, Berke, Mosher and Barker

Arising out of the phenomenological and existential philosophies of the 1950s and 60s, coupled with general systems theory, Laing argued that psychoses were the product of dysfunctional family communication and upbringing and represented a sane response to an insane society. Leaving mainstream psychiatry, Laing set up his own residential treatment centre in Kingsley Hall, in the East End of London. Laing's writings drew upon these philosophical sources coupled with many ideas from psychoanalytic psychotherapy, in particular those of defence mechanisms in order to explicate the experience of psychotic breakdown (Laing 1965). While such accounts might, if true, help us to understand what a person suffering a psychotic breakdown experiences, they do not lead to clear recommendations on how to communicate or treat them, other than conveying that understanding. The main account of treatment at Kingsley Hall supports the idea that communicating such understandings was the treatment, in addition to allowing and facilitating the psychotic process to take its course. Laing's stance never received wide acceptance in psychiatry, let alone by psychiatric nurses, although it does have some supporters. The concepts and the language in which these ideas are conveyed are not easy to understand, nor do they have ready, easy or certain applicability to dealing with the acutely psychotic person. However the idea of being with the psychotic person and trying to grasp or understand their experience was well received by psychiatric nurses, although difficult to put into operation and not well described in the psychiatric nursing literature.

One of Laing's co-workers, Berke, went on to found the Arbours Centre, a charitable institution which still offers treatment in this form today. Treatment at the centre has been described in a number of papers and books, and consists of tolerating the extreme emotions of the patient in an accepting manner, being with them, and expressing understanding of them in psychoanalytic terms (Berke 1987). Some elements of therapeutic community practice are also present, with regular community meetings being held. Therapy is seen in terms of a working through of psychic pain, and the therapists live and eat together with the 'patients'. The Arbours Centre does offer that rare thing, a fully explicated model of how to interact with acutely psychotic people. However it is not one that can readily be followed in an acute psychiatric ward where the backbone of treatment is through medication, stays are short and often compulsory, nurses and their superiors are not in psychoanalytic therapy, and the psychotic experience is not viewed as one of personal growth and development but rather something that prevents and disables such growth. In addition, the Arbours literature does not seem to explain how they deal with violent incidents, inter-patient bullying, serious self harm and other disturbed behaviours that tax the abilities of psychiatric nurses. However the kindness, respect, warmth and egalitarianism shown by Arbours staff to their residents are very clearly transferable. While there does not exist a clear historical link to psychiatric nursing practice, these human values are very much a part of psychiatric nursing as they are of the Arbours approach.

In the US, dually inspired by phenomenological philosophy and by contact with Laing and Kingsley Hall, Mosher created Soteria method. This was remarkably similar to the Arbours centre, but without the psychoanalytic orientation (Mosher 1999). Thus the

focus is on being with the ill person and building a non-intrusive empathic relationship, without the use of neuroleptic drugs. However there was still a longer term attempt to develop a meaningful understanding of the psychotic experience based upon the person's interpersonal circumstances and history. Soteria House itself only operated for a few years, although it has more recently been replicated in Berne, Switzerland, and does have some evidence for its efficacy (Calton et al. 2008). The model cannot really be claimed to have influenced psychiatric nursing practice in the UK, and is not completely distinct from that of Berke (interestingly articles from one do not cite the other). Just as with the Arbours model, its value base and focus on empathy does have common ground with psychiatric nursing practice, and provides a model to guide the encounter with acutely psychotic individuals. However once again, how difficult behaviours and reluctant patients are dealt with is not described, leading to the suspicion that the approach would not be applicable to acute psychiatric wards and their patients without considerable modification. It is difficult to conceive of hostile, paranoid, non-insightful and highly deluded patients being willing to freely stay in such an environment, let alone engage in some proffered therapeutic process.

An attempt to import some of these ideas and ideals into acute inpatient psychiatric nursing has been made by Barker with his Tidal Model (Barker 2001). This attempt at defining a nursing model specifically for psychiatric nursing is difficult to tie down and summarise. Metaphors of tides, water and ships are prevalent, sources drawn upon are diverse, and the ideas are often contradictory and jostle side by side with each other. Yet for all its flaws, the model does get some way towards expressing the nub of actual psychiatric nursing practice and interaction with patients. That is, listening to the patient narrative and understanding of the situation, and hearing that with respect, things which represent the beating heart of psychiatric nursing. The model is humanistic and person centred in Rogerian sense, which is why it is accepted, recognised and welcomed by many practicing nurses. However other than this core emphasis, interactions with acutely psychotic patients are not further defined or described, and issues around psychiatric coercion and difficult patient behaviours are not clearly explicated.

Milieu therapy and modified therapeutic communities

A rather different stream of psychiatric practice that has permeated acute inpatient psychiatric nursing practice was that of therapeutic communities, a British innovation associated with the work of Maxwell Jones in the 1940s (Jones & Bonn 1973). The common attributes of such communities are (Kennard 1998): an informal and communal atmosphere; group meetings central as fora for sharing information, decision-making, feedback, and generating cohesion; shared work of maintaining and running the community; shared authority and a flattened hierarchy; a therapeutic role for residents; and underpinned by moral values and beliefs about the interpersonal and social nature of psychiatric difficulties, therapy as a learning process, and basic equality. Therapeutic communities have had a major impact on the care and treatment of people with personality disorders, drug and alcohol dependencies, and criminal behaviours. However for a period they were also adopted by some leading acute psychiatric wards in a modified form. Certain elements of the therapeutic community ideal spread to nearly all acute psychiatric wards for a period, especially the notion of a weekly community meeting with some shared governance and therapeutic learning responsibility, coupled with the idea of egalitarianism between staff and patients and evidenced by the abandonment of nursing uniforms.

Attempts to implement this approach on acute psychiatric wards are not without major difficulties, particularly in relation to acutely psychotic patients. Acutely ill patients are often not able to communicate easily, and are not in a fit condition to assume responsibilities towards running a community. In the case of psychosis, the idea of social causation, and social learning as an effective therapeutic method, are both open to serious question. Nevertheless, acute psychiatric wards in the UK are populated by more than just those suffering from acute psychosis, and even those patients usually

make a recovery during their stay making them fit to engage with therapeutic community activities to some degree. Thus the therapeutic community notion continues to be present in psychiatric nursing practice to some degree, and from time to time is rediscovered and re-implemented or re-energised (Mistral, Hall, & McKee 2002).

Similar and parallel innovations in the US came to be known as milieu therapy (Gunderson, Will, & Mosher 1983). The concept of milieu and milieu as a form of treatment was broad and never completely fixed, and drew on multiple sources. Patient involvement was drawn from therapeutic communities proper; validation or being with the patient was drawn from Mosher and Laing; finally the idea of structure encompassed rules, routines, hierarchy, herding or group care (in the Goffman sense, but non-pejoratively), and behavioural modification systems of every hue, and drew on a similarly wide range of sources, from Bettelheim, through Menninger to the work of Ayllon and Azrin, and Paul and Lentz. There was thus a sense in which milieu therapy 'meant everything to everyman', incorporated a wide range of treatment modalities, and therefore specific recommendations on practice or on interaction with acutely psychotic patients were rare. The literature argues, with a degree of weak research support, that intensive milieus with high levels of staff-patient interaction, patient involvement in decisions and responsibilities, and with an ideology that psychosis was meaningful and needed to be worked through, had good outcomes for non-chronic sufferers of schizophrenia. However none of this literature gets down to the actual detail of the nature of staff-patient interactions.

Psychotherapy, solution focussed therapy, person-centred therapy and pre-therapy

The psychotherapy literature might be thought to offer some helpful indicators on how to interact with acutely psychotic patients. Unfortunately the vast majority of the psychotherapy literature of any sort has been written about the treatment of non-psychotic people and about outpatients. There is little specific writing or advice about the inpatient care of people with acute psychoses.

In the sole book about inpatient group psychotherapy (Yalom 1983), the main potential therapeutic processes are identified: instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the family group, development of socialising techniques, imitative behaviour, catharsis, existential factors (death, freedom, isolation and meaninglessness), cohesiveness and interpersonal learning. Although his work is now of some vintage, being over 25 years old, it continues to be rediscovered and applied from time to time (Grandison et al. 2009). While Yalom does talk about offering patients support, valuing them, respecting and understanding their experience, all applicable to interactions with psychotic patients, the therapeutic processes he identifies are all considered to be the way in which group psychotherapy operates for 'higher-level' (i.e. not acutely psychotic) patients. Of this 312 page book, only 12% is devoted to talking about group therapy with acutely psychotic patients, and the recommendations consist of structured small group activities of the type routinely conducted by occupational therapists and nurses (Remocker & Storch 1977). There is little specific advice on interaction with patients in these states, other than that they should be 'supportive'. Yalom thus takes us no further forward than Laing, Berke, Mosher and Barker.

Alongside Yalom, a variety of sources recommend the use of 'supportive techniques' with acutely psychotic patients, emphasising acceptance, affection, partnership, optimism, respect, empathy, reassurance, encouragement, advice and problem solving (Lakeman 2006). Whether such approaches constitute a therapy (i.e. used in the belief that they will produce symptom reduction or permanent change) can be questioned; and they can perhaps better be understood as normal expressions of care, or even a moral stance towards those in any psychological distress. As such,

they are definitely applicable as a ways to talk with and spend time with those who are acutely psychotic, and can be readily integrated into everyday psychiatric nursing practice.

Early behaviour therapy research during the 1950s and 60s did examine staff and patient responses to the psychotic behaviour of long stay inpatients who were considered to be chronically ill. In particular the research looked at how other patients and staff acted so as to reinforce (or not) the expression of psychotic symptoms (pacing, aggression, psychotic talk, shouting). Observational research did show that symptomatic behaviour in this patient groups was sometimes positively reinforced by nurses, although appropriate behaviour was also particularly well rewarded by qualified nurses and other patients (Gelfand, Gelfand, & Dobson 1967). Intervention studies showed that such behaviours could be substantially by nurses via positive attention to normal behaviours and ignoring the symptomatic behaviours (Ayllon & Michael 1959). Thereafter such approaches to care of chronically ill patients were widely used in token economies or other behavioural rehabilitative strategies. However these patients were not necessarily acutely psychotic. Their behavioural disturbances may have more been a product of the institutional environment than their illness. Simple suppression of psychotic symptoms might be achievable through behavioural reinforcement. However suppression is not equivalent to therapeutic change, and generalisation to settings outside the hospital is completely unproven, as is any endurance of change past the time as which the behaviour therapy ends. Moreover, suppression of symptoms and the failure of staff to listen to the psychotic experience might well accentuate patient sense of difference, exclusion, loneliness and stigmatisation, thereby making depression or even suicide more likely. Thus it is sad to read statements that nurses' efforts to listen to and understand the patient are to be considered intermittent reinforcement of psychotic behaviour (Gelfand, Gelfand, & Dobson 1967).

Solution focused or brief therapy has also been applied, albeit rarely and with little in the way of evaluation, to acute inpatient care (Macdonald 2007; Vaughn et al. 1995). This type of therapy is geared towards helping patients find and implement their own solutions to their problems whilst monitoring their own progress and the impact of changes they are making. In order to function, this type of therapy requires patients to be able to engage in meaningful dialogue, and as this is not possible for some acutely psychotic individuals, it is therefore not universally applicable. In addition some contortions are necessary to apply it within the framework of compulsory detention, and it only caters for strictly therapeutic conversations geared towards problem solving. However it does provide a formula or approach that facilitates meaningful and acceptable dialogue between nurses and patients, shaping a collaborative and positive relationship.

The influence of Carl Rogers' person-centred therapy (Rogers 1961) has been enormous. Not only have specific techniques such as summarising, paraphrasing and reflecting, entered nursing through communication skills training. The values and attitudes which form part and parcel of his humanistic approach have been adopted by psychiatric nurses and many others. These attitudes include: warmth, genuineness (congruence), unconditional positive regard (acceptance, caring, or prizing), empathic understanding, and non-judgmentalism. These attitudes or fundamentals of human person to person care have probably been more influential than the psychotherapy with which they are associated. As a psychotherapy, the evidence for a positive impact on people suffering from psychosis is poor. The approach might make people feel accepted and understood, but being accepted and understood does not necessarily lead to therapeutic change in psychosis. However the processes of listening, accepting and demonstrating empathic understanding does provide a framework and some suggestions on how to communicate with acutely psychotic patients who can engage to some degree in dialogue. However no specific advice is offered on how to respond to delusional material, thought disorder, hallucinations etc., beyond seeking to understand what that feels like and convey that understanding.

The pre-therapy of Prouty and colleagues is specifically designed for use with those suffering acute psychosis, and draws upon Rogers for its inspiration (Prouty 1994). The method consists of five techniques: situational reflections, facial reflections, word for word reflections, body reflections and reiterative reflections. These methods do not require verbal ability on the part of the patient or dialog with them. Instead they create 'contact' with the patient, with contact construed as the elicitation of some form of person to person recognition and interaction in the real world, as opposed to the withdrawn inner world of the patient's psychosis, or alternative self-awareness (contact of the person with themselves). Some authors make large claims for the therapeutic impact of pre-therapy (Pörtner 2002) with little evidence other than personal experience. Most of the accounts simply do not translate to acute psychiatry – they are with institutionalised chronic patients, and much of the re-contacting is about getting past the institutionalisation, not the psychosis (Pörtner 2002; Van Werde 2005). The institutional care described is of a poor quality, and many of the patients described clearly do not need hospitalisation. The patients are constantly very ill and handicapped – equivalent to high support hostel residents, perhaps, in the UK, and the management are weak and distant. The basic nursing described is deficient and applying pre-therapy masks the issue. Nevertheless these are five useful techniques for use with withdrawn and generally uncommunicative patients suffering from acute psychosis. In addition, the whole approach usefully underlines the importance of being with the patient, knowing who they are and what their interests and pre-occupations are, rather than doing things to them.

For nurses who are psychotherapeutically informed, the nurse-patient relationship is seen as the focal encounter in the process of therapy. Psychotherapeutic approaches in mental health nursing (Winship et al. 2009), have been realised in the high quality practice in at least some institutions. In particular, the focus has been on the nurse as therapeutic agent who applies psychotherapeutic interpersonal skills across a range of therapeutic encounters, either in individual practice, group therapy or in the psychotherapeutic milieu as a whole. Mostly psychoanalytically inspired, such approaches to psychosis can be characterised as more assertive and combative than those inspired by Rogers (Jackson & Williams 1994). It has been shown that nurses can assume a much more active role in the formal psychotherapy process without compromising their potency in the milieu. Attempts have been made at integrating the role of nurse and therapist in so far as nurses carried an individual case load seeing patients for sessions at least twice a week and sometimes up to five times a week where necessary (Bell 1997; Jackson & Crawley 1992; Jackson & Williams 1994; Ritter 1984). The approach of the nursing staff was not psychotherapy per se, and the nurses were not employed as psychotherapists, but intensive supervision, a high level of teaching and psychotherapeutic training can ensure that the patients receive a substantial psychotherapeutic intervention. However none of the literature from this tradition can be summarised into a set of simple recommendations on interaction strategies with the acutely psychotic, instead requiring for its application a high degree of training and education, and dedicated therapist-patient sessions.

Expressed Emotion, psychosocial interventions, and cognitive behavioural therapy

Up until the 1980s, the most effective treatment to reduce symptoms and the risk of relapse has been treatment with neuroleptic drugs. Two strands of research have made a significant difference to this picture, demonstrating that psychological and social interventions can reduce symptoms and relapse too. Although it is unlikely that these treatment methods will replace medication, they do constitute a way of delivering significant additional benefit to patients. The first strand of research that demonstrated that this was possible focused on the family care environment, showing that hostility and criticism of the ill person (high expressed emotion), exacerbates the illness (Tarrrier et al. 1989). The second strand of research successfully applied

existing cognitive-behavioural therapy techniques to the management of reduction of the symptoms of schizophrenia. This research showed that the intensity with which delusional beliefs were held, and the disruption caused by hallucinations could be reduced through a form of verbal questioning, belief modification, and experimental reality testing. The resulting therapeutic techniques, often called together 'psychosocial interventions', are mostly offered to patients when they are well and living in the community. However there have also been endeavours to implement them on acute psychiatric wards, with some evidence that they have a positive effect (Drury 1994;Drury et al. 1996a;Drury et al. 1996b).

With respect to high expressed emotion, this has been identified as present in staff (Van Humbeeck et al. 2001) and associated with high levels of symptomatology (Kuipers & Moore 1995) although the direction of causality has not been established. Given that in family environments expressed emotion is known to precipitate relapse, it is a reasonable deduction that staff should ensure the tenor and content of their interactions with patients is warm and nonjudgmental rather than hostile and critical. Strikingly, these ideas take us back to Carl Rogers. Given the challenging nature of the behaviours of acutely psychotic patients, following this recommendation might be more difficult than it first appears.

There have been several publications on applying cognitive behavioural techniques on acute inpatient wards to people suffering acute psychoses (Clarke & Wilson 2009) plus a report on our own work in this area (McCann & Bowers 2005). The full range of CBT techniques are not applicable to acutely ill patients as they require the ability for introspection unavailable to patients in florid psychotic states. Despite this, lower level and more simple techniques, such as relaxation training, and coping strategy enhancement have been applied in the inpatient setting leading to higher level interventions such as relapse prevention work and psycho education once the psychosis has stabilised (Forsyth et al. 2009). In descriptions of these techniques, however, the interactions utilised in florid states of psychosis are poorly described and many of the pioneering research studies in this area actively excluded people with florid symptoms. An adaptation of CBT and so called "Mindfulness" techniques taken from meditative philosophies has also been adapted for people with psychosis. Acceptance and Commitment Therapy (ACT) has been said to prevent the rehospitalisation of psychotic patients (Gaudio & Herbert 2006), but again the interventions seems to assume a level of functioning that is often beyond a person with florid symptoms. These interventions are extremely novel and have yet to gain a wide implementation or examination.

These ways of ameliorating psychotic symptoms do provide one available framework for therapeutic interactions between nurses and patients. Reducing expressed emotion is more widely applicable and can provide a backdrop or context to all interactions between professionals and patients on the ward.

Potential lessons from dementia care

While authoritative and detailed writing about communicating with acutely psychotic patients is scarce, a considerable amount is available on communicating with those suffering from dementia. While not everything is transferable due to differences in the nature and experience of dementia and acute psychosis, some things clearly are applicable, and there is great potential for cross fertilisation. One work (Killick & Allan 2001) highlights the skills used in starting conversations, maintaining them, and ending well with good feelings and a sense of completeness. Many ways to bring conversations to a positive end are offered: take time; give cues verbal and nonverbal (have to go in a minute, other tasks waiting, sit on edge of chair); thank for conversation and say what you have enjoyed, perhaps summarise content; leave time to hear their feedback if they want to make some; develop an ending routine that can be reused with the same person again to generate habit; say you'll come back and are looking forward to it; leave a card; tell them when you will be available again.

Validation therapy (Feil 1993) is a more theoretically inspired approach that aims to help people with dementia deal with developmental tasks carried over from previous phases of their lives. However most of the fourteen techniques of validation therapy (factual questions, rephrasing, using polarity, imagining the opposite, reminiscing, using ambiguity, mirroring, tone of voice, linking the behaviour with unmet need, identifying and using the preferred sense) can be utilised to some degree or other in conversations with the acutely psychotic.

Fundamental to both these works is an understanding of the experience of dementia, what it does and doesn't change, what people with dementia might feel in different situations and contexts. As such it demonstrates an acute sensitivity. It is hard to think of any such professional account of acute psychosis. Most accounts are objectified (i.e. accounts of behaviour and symptoms) rather than truly phenomenological. Therefore a good starting point might be patients' accounts of being ill or user poetry, whilst acknowledging that such accounts can be distorted by the illness itself. Again, interestingly, nearly all approaches to communication with people suffering from dementia draw upon Carl Rogers' psychotherapeutic ideas and values.

Summary and aim of this work

Previous work does have some significant guidance to offer the practicing psychiatric nurse who is caring for an acutely psychotic person and who wants to communicate with them effectively and therapeutically. The goals of that interaction would be to keep the patient and others safe, accurately assess their mental state, deliver appropriate treatment (physical, psychological and social), and ensure that their physical health and needs are catered for. The foremost things the literature offers is the importance of basic listening and communications skills, coupled with a set of attitudes and values that sees the person and their experience as important and to be understood as well as possible. Ways of working have been developed that allow nurses to spend at much of their time as possible in contact with a small number of patients, so as to develop these processes. Some additional therapeutic or interactional techniques have been described, such as supportive psychotherapy, pre-therapy, solution-focused therapy and psychosocial interventions, all of which harmonise well with the fundamental attitudes and values of Rogers' person-centred therapy. A further few can be readily borrowed from developments in caring for dementia patients. These, and the ventures from outside of mainstream psychiatry, all emphasise the importance of deep respect for, and interest in the acutely psychotic patient as a fellow human being.

However while these sources do give us some useful tools, there is a sense in which they do not go far enough. The literature does not really tell us how best to spend time with the deluded or hallucinating patient. There is an over emphasis on dealing with those patients who are comparatively well, and certainly on those that are co-operative, insightful, and friendly. However many acutely psychotic patients on acute wards can be deeply unwell, severely deluded, suspicious, hostile and aggressive, and incredibly challenging to spend time with, let alone provide care to and treat. Here the literature and previous work seems to be silent, hence this research was undertaken to discover if there were untaught, traditional or self-developed skills amongst nurses identified as being highly skilled with acutely psychotic patients.

THIS STUDY OF INTERACTION

The interviews

The aim of our study was therefore to seek to identify nurses' skills and methods in working with acutely psychotic patients which were not already well-known or formally taught. We were looking for traditional practice learnt perhaps from watching others, tacit knowledge not previously formulated, and to draw upon expertise gained through experience. We worked with the managers and nursing leadership of three London mental health NHS trusts to initially identify a few practicing qualified psychiatric nurses who were acknowledged experts in working with acute psychotic patients. We then interviewed them, also asking them to nominate others whom they knew and thought of as particularly expert, a strategy known as snowball sampling. The nurses identified were currently working in community and inpatient posts, and we collected 28 in total. Just over half (53%) of the sample were female, with most currently working in the community (75%). Roughly equal numbers came from each of the three Trusts involved in the study. The interviews were all digitally recorded and transcribed so that we could analyse them with the aid of specialist computer software (N6).

Our interviews were semi-structured, in that they consisted of a framework of fixed questions, however the interviewer had freedom to follow leads and diverge from the schedule when appropriate. We devised the questionnaire based on our experience, round table discussions about the nature and pattern of acute psychosis, reviews of research instruments to measure illness severity (Theodoridou et al. 2008), and on parallel work to construct our own scale (the Nursing Observed Illness Intensity Scale). The full interview schedule is in the appendix to this monograph.

Analysis

All interviews were firstly read in detail by the Principal Investigator (LB). Initial coding followed the structure of the interviews, where subjects were asked in turn about communication with apathetic and withdrawn patients, then hallucinating patients, deluded patients, thought disordered patients, agitated or overactive patients, upset and distressed patients, and irritable or aggressive patients. All statements by subjects were then coded at a finely grained level under each of these categories. These were then grouped under each symptom area into eight preliminary domains: preparation-context; initiation; style-approach-values; content-duration-frequency; metacontent (talk about the symptoms not aimed at reducing or ameliorating them)-therapy; self-monitoring; coerce-assert-persuade; and task accomplishment. These code headings were then assembled in a large table (symptom areas as columns and preliminary domains as rows) and discussed with the research collaborators, the City University MH research team, and Dr Rose McCabe as an external expert in the area.

Several plans for higher level groupings of the data were examined and discarded at this stage. The division of strategies into core versus periphery was discarded because the dispersion of codes meant that any 'core' was extremely small. Division into basic, intermediate and advanced strategies was also abandoned, as there were no criteria within the data on which to base such distinctions. Instead some of the preliminary domains were merged, others kept and some divided to produce seven themes, whilst acknowledging significant overlap.

In terms of presentation, it was decided to present the common themes across symptom categories first, followed by material which was specific to the patients presenting specific symptoms. Codes were determined to be common themes if they existed across at least three symptom areas. The pattern was followed for all domains except 'talking about symptoms', which generally contained only specific material. As the analysis progressed, it was possible to collapse a number of existing codes into larger categories. However some codes remained as being mentioned by only one interviewee, and unless they were judged as yielding a particularly valuable insight, they are not included in the analysis below.

The next five chapters cover the main findings from the interviews: moral foundations; preparation for interaction and its context; being with the patient; nonverbal communication, vocabulary and timing; emotional regulation; getting things done; and talking about symptoms. Identified communication strategies are introduced by subheadings, and are further subdivided where necessary. Numbers in the brackets indicate how many interviewees mentioned the specific strategy; for example 15/28 means that 15 of the 28 interviewees spoke of the strategy or method concerned. Illustrations have been provided (all by Geoff Brennan) to aid understanding.

MORAL FOUNDATIONS

There was considerable cohesion in subjects' responses under this heading, with most being generic across all symptom domains. Five different aspects of the moral stance that nurses took were apparent and well represented in the interview data.

Notice, do not ignore (19/28)

This was expressed in a variety of responses to patients' behaviours, including not 'forgetting' about apathetic patients, 'allowing them to be left out' or 'leaving them to rot in their beds', giving as much attention to the negative symptoms (apathy/withdrawal) as the positive (all others); talking to patients about their hallucinations and delusions, rather than ignoring them, changing the topic when patients brought them up, or ignoring the patient as 'too unwell to try and engage with', as 'even if it's nonsensical it is still communicating'; giving 'extra attention' to those who are anxious or agitated, rather than less, not 'sending them to their room and just leaving it'. Noticing meant not dismissing patients' symptoms, overtly writing them off to patients as 'not real' or 'symptoms of your mental illness', as 'dismissing their reality would be a big no, no I think on the whole'. The consequences of so doing are to generate antagonism and a sense of abandonment: 'to dismiss their symptoms out of hand is going to make it very confrontational and they're not going to feel that you're listening to them or helping them in any way ... destroying a relationship'. Ignoring symptoms meant that nurses would preclude understanding 'how, what their experiences are and how the symptom is affecting them in their function and in their emotional state', and this in turn meant that no therapeutic work could be undertaken. In addition, noticing symptoms prevented nurses from making mistaken assumptions about patients' experiences: 'what people describe as hearing voices or hallucinating is often, what we consider those things to mean isn't necessarily what the patient or the client considers them to mean'.



Encouraging, supportive and gentle (23/28)

Being gentle with patients meant 'not shouting', but rather going to the patient giving him or her quiet advance notice and suggestions about what they might like to do, having a low emotional content and a slow, quiet approach. It also meant not being rushed, but 'respecting the pace at which it is comfortable' for the patient concerned, and avoiding any sense of 'force', 'argument' or 'pushiness'. One respondent referred to a 'sandwich' technique, in which the patient is listened to and heard first, nurtured, prior to suggestions being offered about helpful things to do, or what needs to be done now. Being supportive was also about not being 'domineering, or taking control, telling people what's good for them', but using a more passive, sympathetic and suggestive style of approach such as 'just put it into that, let's see if this helps'. Similarly, when information is needed 'you don't bombard them with a lot of questions, you perhaps just gently tease things from them'. Encouragement was also about feeding back positive judgements, evaluations, reassurance and reminders: 'highlighting their abilities and their skills and the positive issues that they can look forward to will make any tasks easier, increasing their self confidence and motivation'. Others emphasised the combination of 'understanding', 'sympathy' and 'encouragement' to do things. Sometimes the degree of support rises to the point where nurses do things for patients where they simply cannot do them themselves, for example washing them. Being encouraging, supportive and gentle means giving patients 'space', taking 'time' and

requires 'staff availability', however not doing them was recognised by nurses as likely to exacerbate anxiety and hence other psychotic symptoms.

Empathy and concern (19/28)

"Let them know that you're genuinely, concern, show genuine concern, be empathetic to them. Be there for them, getting them to know that you're concerned about their wellbeing and you're, you want to help them and support them at the difficult times, for them to get better."

This was seen as a fundamental element of every approach to patients, and was talked about in a number of different ways, including seeking to 'understand more what the patient is going through', being 'compassionate', 'empathetic', 'warm', 'expressing concern'. More everyday terms used were being 'motherly' or 'friendly', and definitely not expressing boredom in response to patient symptoms or distress. Without this 'caring attitude' it was recognised that patients would not trust the staff, and without that it was much more difficult to help them in any way at all. The way these things were demonstrated by nurses behaviours were in 'tone of voice', 'giving time', being responsive to patient distress, offering help and by verbal statements of concern, even in the face of aggressive and other challenging behaviours. An approach of 'love, empathy, concern and kindness' was viewed as having the potential to eventually dissolve patient anger and alienation, and would be remembered and appreciated by them as they improved.

Honesty (10/28)

"Being honest with them, letting them know what I am prepared to do and what I am prepared not to do and what I cannot do. Honesty and being straight and upfront with them."

This involved such things as telling the patients that they might hold certain delusional ideas, but these are not shared by the staff, then negotiating around that difficulty. Explaining truthfully why you want patients to undertake a particular task, such as taking medication, or being truthful and giving away some information about yourself in conversation with patients. It also involved honestly admitting when services had failed or gone wrong, not pretending to understand what patients were saying when they are thought disordered, telling patients the real reasons they were legally detained in hospital even if they did not want to hear them, being realistic on the limitations of psychiatric treatment, being truthful even in the face of patient anger, and in particular being genuine about expressing care and concern to patients.

Don't intrude (20/28)

"You have to judge how, I think how frequently you approach somebody or how you talk to them or how it's, it's a case of being and acknowledging that as well that you don't to, you don't want to intrude, you don't want to be intrusive but you really want to be there for them to talk to. You really want to be someone that they can come and ask questions or, but you know, it's using your judgement in that way."

Nurses recognised that psychotic symptoms could be experienced as deeply 'private', personal and 'intimate', and that to speak of them was 'almost like talking about sexual fantasies'. In their eyes this partly accounted for patients being unwilling to talk about

their symptoms, or being very guarded in what they were willing to say. Thus patients could perceive too much detailed questioning about their symptoms as threatening or transgressing the boundaries of allowable conversation between relative strangers. For withdrawn or distressed patients, any attempt to interact ran the danger of being more intrusive than the patient could tolerate, thus nurses spoke in terms of making themselves available for the patient to choose to converse: 'acknowledging that they're upset and if there's anything I can do, that will give them room to actually if they want to talk'. Or being careful to adhere to the normal etiquette around knocking on doors and entering rooms, keeping any conversational attempts short, rather than 'prying' or 'trying to tease lots of information out of the person' or 'imposing your presence on them', and limiting the numbers of people participating in or witnessing the conversation. Other expressions of this low key approach were 'being visible without being intrusive' and 'not harassing' patients. All of these were ways in which nurses sought to moderate the perceived intrusiveness of their attempts to interact with patients. When nurses had pushed too far or intruded too much, they then knew that they had to tolerate the patient's angry response: 'not taking offence if someone says, I don't want you to be here, please go away or in slightly more direct terms than that.'

"And not really pushing them to communicate very deeply about what's going on, cos often some of those ideas can be really deeply held and really frightening to hold, so therefore I don't really push them to expose those ideas very quickly".

Respect (22/28)

"You respect them. You never think, even if in your head you're thinking this is total rubbish. Delusional nonsense. You must not let that seep out into your perception of them as a person. Or the way in which you're interacting with them."

To the interviewees, respect meant not making fun of or laughing at patients, their behaviour, or their delusions, even while admitting that 'there's something quite comical sometimes' and that 'any member of the public would be laughing'. One interviewee reported: 'when I see it, trust me, I deal with it, I don't like it. You should never disrespect people's beliefs even if you know that they are delusional beliefs.' It also meant a commitment to trying to establish and hear the patients' point of view, rather than just control their behaviour through verbal instructions; being polite and apologetic to angry and agitated patients. One subject explained that this was the opposite of a confrontational and authoritarian style, and that the same thing can usually be communicated in 'a respectful quiet manner'. Respect was also about not being condescending, critical, demeaning, treating patients like children or 'making them look silly in front of their friends'. Instead it is about giving them as much independence and responsibility for themselves as possible, while at the same time acknowledging their personal reality and symptomatic experiences.

"This man for example, he would write things out by hand. And I'd get them typed up. And they were very delusional. But what was fascinating if you read them, and he had certain beliefs about how nurses should interact with patients. He wanted to give the ward something as a professor of ethics. So I got them typed up. And when they were hand written they looked complete, it was all big writing. But when you typed them and read them, although they were delusional, you could make sense of them in a weird sort of way. And I think by treating him with respect you can get to a core of something he's trying to communicate, and I think it's that level of respect, it's that level."

PREPARATION FOR INTERACTION AND ITS CONTEXT

Again, most of the material under this heading was generic to patients exhibiting all symptom areas. However some of the specific choices were differently nuanced, and these are described below where relevant.

Observe first (20/28)

Before choosing to try to interact with a patient, it was recommended that the nurse 'observe' or 'read' the situation, 'gauging how somebody is'. This would allow the patients level of distraction by hallucinations, mood, agitation, irritability or other symptoms so that the appropriate approach can be made. To do this required nurses to 'have some experience in reading into presentation, symptoms and how to deal with each presentation', looking at their behaviour, facial expression, movement, perspiration, respiration, hygiene, neatness and other nonverbal cues. It was accomplished by 'being peripheral ... taking a seat, watch for a bit, get a sense of what's going on, how that person's impacting on other people'. Such observation, reflection and assessment continued once conversation was started, so that the nurses' responses could be continually adjusted to the patients' behaviour: 'one moment she was charming, the next moment she was quite aggressive and I think that, I noticed the longer the conversation was going on the more it, she was inclined to become aggressive just because of the impatience'. One nurse referred to this as 'treading very carefully' because patients could respond in unpredictable ways due to their symptoms.

Consult case notes (9/28)

The previous case record was a source for three very useful pieces of information. Firstly the patient as a person, their 'background' and interests, thus yielding potential topic for conversation or type of activities that they would be more likely to respond positively to, or which could be used to counter some of their symptoms. Secondly, it provided information on what interventions and approaches 'had worked in the past or hadn't worked in the past' with this particular person. Lastly, the record provided information on the level of risk posed by the patient, whether they had been violent in the past and to what degree, what things are likely to 'make the person more irritable', or whether 'their bark was worse than their bite' and they could be approached with a greater degree of confidence.

"You have to gather as much information as you need in order to have any kind of contact or interaction with a patient with any diagnosis".

Consult friends and family (9/28)

Either to provide information on patients usual interests in order to utilise this to facilitate conversation, build relationships and set achievable goals for improvement, or in order to elicit support and help for the patients themselves.

"It's about trying to hook in to see if there are any hooks in what they're interested or what they've been interested in in the past, ring their parents to see if you can find out".

Choose the right nurse (16/28)

Sometimes it was important to choose the right nurse to make the approach. This was perhaps particularly important in choosing who would lead on trying to de-escalate tense situations, but was also relevant for choosing who would be more likely to be able to 'give reassurance' to a distressed patient, calm an agitated patient, or win co-operation from a reluctant patient for medical investigations or whatever. The relevant issues for such a judgment were the nurses' age, gender, culture/ethnicity, relationship with the patient, available skills, and sometimes intangible elements to do with the interpersonal styles of individual nurses and how they fit with the patient concerned.

"If someone's very distressed or there's been very bad news then that's certainly appropriate time for nurturing ... if you've got someone who's able to do that at that point then often more experienced member of staff or someone in, older. So even someone just, who they get on well with. So hopefully you'd be looking at who was, who you consider the most appropriate person to be."

Choose the best time of day (14/28)

Nurses noted that symptoms could 'alter quite a bit even during the course of the day', and 'that would alter what you can do with them'. Energy levels could also fluctuate, influencing the likely success of trying to get a task or activity completed, as well as engage successfully in conversation, or patients could be more relaxed at certain times. Nurses therefore looked for 'windows of opportunity' to get things done.

Choose location (22/28)

Selecting the right environment for conversation was deemed to significantly affect the likelihood of success. Several aspects were mentioned, the most frequent being trying to secure a location that did not over stimulate the disturbed and symptomatic patient. Corridors on the ward were considered particularly problematic, because 'there's lots of other stuff going on' and 'you're dead in the water'. Too much stimulation from other activities, people, noise and conversations was thought to exacerbate psychotic symptoms such as irritability, overactivity and hallucinations:

'the wards are so chaotic that if in your head you're very chaotic at that time, then obviously the chaos of the ward and the hustle and bustle of every day living is going to be, it's going to be, exacerbate those symptoms'.

Drawing the patient into a low stimulus environment was thought to be particularly important for angry patients who needed to be de-escalated and calmed. A further gain from getting them into a quiet area was removing them from an audience, and reducing the possibility that patients might see any conversation as a 'show of strength' and making sure that they don't have to 'back down' in front of others. However nurses also had to exercise caution about their own safety in such circumstances, as it was not wise to be completely isolated with a potentially violent patient. For other patients, perhaps those who were upset, distressed or were going to talk about their delusions, the privacy of the location was a critical aspect of success. Basic comfort with regard to heating, lighting, fresh air and seating also needed to be

considered, and where possible this could be adjusted to the requirements of the patient concerned. Territorial aspects of the environment could also be used to enhance the potential of success. Going into 'their space' such as day rooms and bedrooms, rather than taking them into offices which might be associated with 'probing' professional psychiatric interviews. Asking the patients what they would prefer was another useful strategy. Choosing the right place also had to be done with regard to the needs of the individual patient.

"So you pick your area where you're going to meet them according to where they feel comfortable and reasonable obviously, but, for example, if somebody hears things from the TV you wouldn't want to be in a room where that's happening. If someone's fearful of something coming from outside you might think that their bedroom might be a more peaceful space than maybe somewhere else. So an awareness of how they feel about where they are."

Set appointment in advance (9/28)

Rather than formal appointments, this was more about giving patients advance notice about when the nurse was going to spend time with them or complete a task with them:

'I would go maybe 20 minutes, 30 minutes beforehand, and explain to them what's going to happen.'

This advance notice allowed patients to psychologically prepare themselves, 'so that actually they can prepare themselves for being disturbed and I think that shows that you're respecting them' and avoided sudden surprises or springing things on patients, a scenario that was more likely to elicit anxiety or noncooperation. Setting a time for talking with patients could also allow them to contain their anxiety over the interim:

'it's this idea that actually I'm a secure base and I will be coming back, I won't be leaving you, it's more you're trying to establish that with them.'

BEING WITH THE PATIENT (RELATIONSHIP BUILDING, MAINTAINING AND ASSESSMENT)

There was a roughly equal balance under this heading between material that was generic, and that which was specific to dealing with patients exhibiting specific symptoms.

Be with, sit with, be available, offer conversation (16/28)

"They might be not be very nice, but just be around and say or even I appreciate you won't talk to me, fuck off, I appreciate that fair enough, but you know who I am, I'll be around if you want to interact"

One way nurses did this was 'letting them know that you are always available when you are around', in other words telling patients that they are available and allowing them to make the approach, giving them the freedom to select the member of staff that they felt most comfortable with: 'remember that I'm always around, and probably in your own good time, when you feel that you're ready to come to me, feel free to do so, but I will always, I will also be looking out for you.' It also meant being consistent in that availability and accessibility, giving time even when the patient is not able to utilise the time to communicate effectively. This was spoken about as 'investing time', implying that the return on that investment might come later rather than immediately. A more active way was to make that availability more prominent by 'sitting down in the room where they are', 'just be in the room a little while' before saying anything and 'occupying the same space'. There could be a thoughtful attentiveness about this presence: 'sitting in the room with somebody and trying to think about ways that soothe them', and 'allowing them the space' to say what is on their mind. This process could not be 'forced', as 'pressurising the patient isn't helpful,' instead nurses had to wait for the right moment, when patients were ready to talk, 'going into their space and being with them'. Slightly more assertive is to directly offer conversation, such as by saying 'do you want a chat?' or 'can we go and talk about this'.



"And in a way it might just be about being there regularly and saying, I'm going to keep a check on you every ten minutes or so because I'm a bit worried about you, and so just a genuine concern for that person and just seeing how they're travelling regularly."

Introduce self, explain role (12/28)

"You introduce yourself and what you are there for, and you make them understand they can come to you for help or if they want to discuss their condition or medication or whatever you're there to do for them. So you develop a relationship."

Having approached or made themselves available to the patient, nurses would wait for that 'little second that they look at you and recognise you are there', and use it to greet the person and introduce themselves (by name), building a rapport by explaining what they are there to do. The nurses communicated that they were there to understand and help in whatever way possible, detailing what kind of help that might be, how patients can access it and trying to show 'the advantages of talking'. Explaining their role also involved explaining what the hospital and ward were for, how they were run, and how work was conducted there, giving information about what they could expect from the services including 'what they would not do' as well as what they would.

Light, casual, normal conversation (10/28)

"You address them the way they would like to be addressed. You talk to them the way anybody and everybody would like to be talked to. You talk to them as individuals, as human beings, with respect."

This could mean being 'respectfully curious' about the patient, learning about their background and experience, what is important to them and what interests them. Depending on their response or interests, this could start or continue with chat about 'general things' – television, sport, football, soap operas, the current news, weather, events local and national, etc.: 'you can always find a gateway to build a relationship and trust'. Thus nurses and patients can end up chatting about 'all aspects of their lives' or 'anything that is going on'. The starting point was for nurses to treat patients as 'ordinary people' and engage them, if possible, in 'normal conversation'.

Focus on the person (21/28)

"I think you need to look at ways in which you can find out what they're like and if possible that involves finding out, I guess from people who know them and trying to key in things that they may have potentially previously enjoyed, or had some kind of meaning for them and try and engage with them with those things."

More specifically, this meant putting to one side for the moment the psychiatric problems and symptoms, instead focusing upon patients as, first and foremost, people rather than specimens exhibiting curious behaviour. Not focusing on the hallucinations, the voices, the delusions and the thought disorder, instead discovering 'the person past the symptoms', all the other aspects of the person that don't necessarily have anything to do with their psychiatric status.

'Trying to find out about the person, what did interest them before everything shut down.'

Knowledge gleaned from other sources (by questioning friends and relatives, or by reading the case notes) could be used to try and create social contact with patients who were disengaged, for example commenting on the football team a patient supports and trying to stimulate or draw them into making a verbal response. Newspapers and news items were other topics utilised by nurses to initiate conversation, draw patients out and learn about them, their points of view and thoughts about the world. Horoscopes, radio programs, TV, films, soap operas, magazines, music, friends, family, children were all other readily available topics for conversation and finding out about the person, whilst setting to one side their psychiatric problems. Asking open questions was a critical technique in drawing patients into person-centred conversations, or simply making comments and awaiting a response. Focusing on the person could also mean exploring their everyday worries and feelings, their natural responses to being away from home and in hospital, or

querying and responding to their normal physical needs around eating, drinking and sleeping. Not just talking about the symptoms, but about all aspects of their care such as 'social care, housing and the things they want to change'.

"Building a relationship is a long drawn process as well, just always trying to talk about a more varied topic of things, because it's all well and good to acknowledge that every time they see you they don't want to always be talking about voices or talking about what their positive symptoms are. Just looking at other things."

Here and now as topic (4/28)

"I'm thinking of inpatient wards where, it's a pretty awful environment, I think, and what you see around you is quite crazy in itself, and then to have somebody who's there, feeling very withdrawn and looking at this scene that they're facing and that's, it's quite an absurd scene area, and they are seeing people who are quite unwell, and who are saying really odd things, and yet we're trying to help make that person better and to be more normal, so to speak, and so I guess just noting what you see. And I guess, in a way it's saying, well yes it's, this experience, it is very odd. It's very strange and it's frightening."

Somewhat related to focusing on the person rather than the symptoms, was assisting the patient to focus on their here and now experience, or using the 'here and now' as a topic in its own right. Here, once again, props could be used, such as 'books, the television, what is going on in the room', 'paintings' on the ward walls, 'factual things' such as sounds and colours on the ward, rather than abstract, theoretical or symptom based conversation. This method could be adopted in order to help with orientation to time (time of day, day of the week, month or season of the year), place (X hospital, N ward), or person (nurse so and so, the ward cleaner, hospital porters, other patients, or celebrities, politicians etc in the news).

Joint activity (22/28)

"Sometimes I might start off doing something myself. And then, then I'd invite the person to join me if it was appropriate, it may not be appropriate at that time, it may be appropriate at another time. But I might start off by doing something just to, so that, that person, I suppose, has the time just to work through their distress and if the person is then able to come and do something with me, that's good."

Another much spoken about way to get socially engaged with patients was frequently recommended: joining what they are doing, or initiating something and asking them to join in. Playing games for example, such as 'scrabble', 'pool', 'card games', and 'playstation'; or being with them and assisting whilst they care for themselves – having a shower or a bath, hair care, shaving, doing their laundry, making a phone call, all provided opportunities for social interaction and relationship building, both verbally and nonverbally.

Two specific activities were mentioned a great deal, so obviously had proved useful to many nurses:

1. 'Going for a stroll, just going to the shop', or if appropriate to the individual patient, walking up and down the ward with them. getting away from the environment of the ward, where possible, was seen as beneficial and aided communication.



2. Eating meals with the patient, or more commonly a possibility, making or assisting them to make a snack or a drink.
A more common standby from the past, smoking a cigarette with the patient, was only mentioned once in the interviews.

"The writing, writing things down, because I've found that that slows the thinking down. Painting, drawing, sensory things as well just like taking someone into the garden, gardening, just doing something, actually something, I think the thing about that is something that actually connects them to something in the environment, something very, very concrete and something that's actually slowing the thought processes down."

Humour (10/28)

"I think a bit of humour goes a long way as well. Even if you're feeling really down you can still, peoples' humour seems to be retained somehow and just sharing a bit of a laugh about what's happening and, just can be a bit of lightening of the load for people and it can build trust as well because I think, if you can laugh with somebody you, it feels a bit more candid. You don't feel like you're necessarily just speaking jargon and you're just representative of the system but that you're, if you laugh together, you're human to human rather than, type of staff member to patient, in a way."

The addition of humour was seen as an expression of 'friendliness', as having the capacity to diffuse tension, anger and anxiety. The fundamental concept here was that the nurse was trying to raise a smile from the patient, rather than utilising patients or others as the butt of mutual humour. Because expression of humour might be interpreted as belittling or disrespectful, nurses expressed a degree of caution about recommending it, indicating that the content, timing and fundamental relationship had to be right for this to work well. Without the pre-existing 'good relationship' it was not felt that humour could readily be risked, and being able to use humour appropriately and well was regarded as a 'sophisticated' technique. More simple uses of humour, such as 'telling a joke' were less risky. Interestingly, utilising humour was mentioned in relation to all symptom areas except delusions and hallucinations, perhaps reflecting the acute sensitivity of patients to criticism of these symptoms. In talking about their own 'sense of humour', nurses also meant their need not to take personally or necessarily too seriously all of the things patients said, particularly their hostility.

"I'm not saying make light of the situation. But you can be a bit more jovial about a situation. But that's something that you would have to have established a very strong relationship with before you could do that."

Apathy/withdrawal specific

Comfortable silence (9/28)

Sitting with the patient, communicating attention nonverbally, and 'waiting for them to make the first move' or simply 'just being with somebody and being able to accept being with somebody in silence', as well as making a greater use of pauses in silences in what conversation is achieved.

"Maybe just sitting with them first of all, just so that they've got the physical presence of somebody there for a while with them first of all."

One nurse mentioned sitting with a patient for 30 minutes without them talking. To accomplish this requires 'not having any expectation that anything's going to happen quickly', 'tolerating silence' and guarding against 'hammering out questions' because of 'your own anxiety'.

"And just having silence at times but not in a kind of dynamic silence ... trying to find a kind of a medium so that people are not feeling bombarded, but at the same time you're not just sitting ignoring each other. So feeling you're engaging with someone and trying to get that fine tune to a level that's comfortable."

One-sided conversation (3/28)

Here the nurse makes all the effort and all the running, sitting next to the person and chatting regardless of the non-response of the patient

'just like I'm having a conversation with them and they're just not answering but, and I can keep that up actually for quite a long time'.

All the time the nurse keenly attends to and watches the patient seeking the smallest response, maybe a 'flicker of a glance' or a 'smile'.

Be creative (1/28)

"So clients I've known, for example, who might be into music but they're just too withdrawn or apathetic to request or organise music in their room, I might get the radio for example and maybe say, well look N, if you want to switch it off, I'll go away and I'll come back in ten minutes see if it's still, and do something like that."

Hallucinations

Tolerating and making allowance for auditory hallucinations (3/28)

Even when just trying to have a normal chat with the hallucinating patient, nurses recognised that they had to make allowance for the reality of the patient's experience. This could be about acknowledging the potential for the patient to be distracted, as the voices might be like 'a radio that can't be switched off' and 'lucid answers' to questions should not necessarily be expected. Thus 'patience' and 'pragmatism' around expectations, coupled with open acknowledgement of the hallucinations as something potentially impacting on communication were all requirements for a reasonably successful conversation.

Not too much too fast (5/28)

Too much stimulation, either through trying to convey 'excessive amounts of information' or trying to communicate with the patient in a very noisy place with lots of people around, were seen as things that hallucinating patients would not be able to cope with. This was perhaps another way in which conversations had to 'accommodate their needs'. Failure to attend to these needs might have negative consequences for the patient, resulting in more 'bizarre behaviour' or even aggression.

Say their name (2/28)

Given the distraction of hallucinations, nurses recommended using the patient's name more than usual in order to get their attention back: 'just saying their name, just to get them back in the conversation again'.

Be creative (1/28)



"I remember once ... we had a young girl who was incredibly suspicious and she locked herself in a room for ages and every time we went in to see her, she'd become incredibly hostile because she was so paranoid and we wouldn't give up really. So it was a case of I'd go in to see her maybe once every half an hour. She wasn't on observations but, and just pop my head through the door and just say, did she want a drink and constantly try and play it down and it took a long time and then eventually we put some music on and we just went in her room and danced with her and it seemed ridiculous but it was something that she was able to respond to. So I think it's a, it's difficult, it's about being creative. It's about trying different things, if something doesn't work then it's not just saying, well that, that person is really disturbed and you can't get through to them. It's about trying different things and that's what we do. It was, it worked for her and every time she became extremely distressed, she'd put music on and she'd dance."

Thought disorder

Acceptance and listening (15/28)

Going along, being patient, waiting for sense to emerge over the longer time period, without 'straightaway feeling you have to say something'. In using this technique the patient is kept going by responses such as 'oh yeah' and nods of the head. Some nurses said they 'enjoyed that aspect of the mind', 'had some affinity with it' and found the process 'creative'. Listening over the longer term enabled nurses to identify 'themes giving you an insight into who that person is, and what's most important for them as well'. Further understanding could then develop as to how the thought disorder was affecting them and interfering with what they might want to do. Nurses could also then 'tune in to how they were feeling', enabling the identification and treatment of distress, and/or better risk assessment. Being prepared to listen for some time also made possible a social connection for the patient that might be 'quite rare for them'. Such opportunities also allowed the patient to ventilate and let off steam. The difficulty in attending and listening to a thought disordered patient was also commented on, as

"while there is no connection between their ideas ... you need to be completely the opposite, maintain your brain in gear and listen to what they say'.

"I follow people's tangents that they go on, I'll just go with them on the ride essentially. And often I think people on the surface are not making much sense, but even in thought disorder I think sometimes people will, the connections they make between a word or a thing seems to be able to, I seem to be able to be able to follow that link and just stay with it in a sense."

Name themes (2/28)

Once themes have been identified through listening, these can be named and attempts made to further discuss them with the patient concerned. Doing this might 'help them to retain some order in their disorder'.

"So if there's religious themes there and you've covered a whole range of areas that have some kind of religious element to it, or like naming that in some way. Or maybe there's a theme around crucifixion, you can say, crucifixion seems to be coming up a lot in what you're talking about, and then that maybe gives a framework by which people can understand themselves as well."

Writing (5/28)

Asking patients to write down what they wanted to say, and bring it on a piece of paper. Nurses suggested that this 'slowed the thinking down' and helped patients realise what they wanted to communicate.

Send away to think (2/28)

When attempts to understand what the patient says completely fail, they can be asked to go away and think about what they want to say and return when things are clearer.

Remind, prompt to topic (10/28)

If the patient thought blocks, then they can be prompted with 'what they've just said'. Alternatively if he or she goes off on a tangent, questions can be repeated or 'gentle reminders' given about the topic of the conversation: 'just keep repeating the question and bringing them back to it' or saying 'can we just come back to this?'. Once again nurses mentioned difficulties in staying focused themselves when patients 'jump from topic to topic', so the use of reminders was helpful to nurses as well as the patients they were speaking with. Keeping the conversation on track was 'like guiding someone through a very dark place, or a jungle'.

"I think the technique as much as anything else should be quite, should be guided. This is what we're talking about, stay on this thread and guide them through"

Keep it simple (6/28)

For example choosing an easy topic of conversation rather than a complex one, and being prepared to change topic in response to patients showing difficulties in communication. Alternatively this could be about helping the patient avoid complex social situations that they are not able to deal with, such as demanding group activities, or 'not bombarding them with lots of information or choices', 'too many new, too many complex ideas', right down to simplifying the language used, not using 'flowery' words and being concise.

Clarification (5/28)

Mixed opinions were expressed here. Some thought that when nurses did not understand they should ask the patient to clarify what they meant, and that when nurses were trying to convey information they should check that the patients had understood it. Others thought that doing so put patients under more pressure, exacerbated their problems in communicating, and were not ultimately helpful.

Agitation/overactivity

Positive feedback (3/28)

Giving positive feedback, recognition on what the patient is doing well and what they are accomplishing, as opposed to being critical. "Give them positive feedback when they are able to sit down with you."

Set interaction limits (3/29)

Nurses recognised that patients with these symptoms could be very demanding and request more staff time than could possibly be given to them. They therefore suggested that if this was an issue, limits should be placed on how often the staff would converse with the patient, and/or on the duration of those conversations:

'before ... I tell them I go five minutes and five minutes only, or ten minutes and ten minutes only.'

Reduce stimulation (3/28)

Excessive stimulation was seen as likely to make the agitated or overactive patient worse. Such stimulation could come from nurses trying too hard to make contact with patients, for example by following a pacing patient, placing such a patient on special observation, or asking them to do more things.



Upset/distress

Reveal self (2/28)

Being prepared to mention one's own experience of distressing events, not to look for sympathy for oneself, but in order to establish a good rapport.

"That's really upsetting, I know when somebody died, when my uncle died I was really upset about that. I wouldn't be adverse about saying, there's a shared humanity here that we have, we share some of this experience and what you're going through is really human and normal, and it's important that we are here together to just survive this."

Limit unnecessary interaction (2/28)

At the point at which someone is acutely distressed, it is not a good time to be asking too many questions or trying to communicate too much information.

Aggression/irritability

Get them sat down (4/28)

Nurses suggested that if you could get the patient to sit down with you, then this had a calming effect that enabled more reasonable conversation: 'you can't feel quite so pumped if you're sat down talking to someone'.

Get the patient to write (2/28)

Communication through writing was seen as a possibility, a way for the patient to express themselves without the risk of them losing their temper in a closer interaction with staff:

'getting them to write down their frustrations and the reasons why they're becoming angry'.

Maintain clarity (3/38)

Making sure that the patient had a good understanding of what was happening and what you are doing, preventing as far as possible any misunderstandings that might heighten or trigger the release of anger. So, for example, nurses suggested checking with the patient how they understood what was going on and why you were talking with them, in addition 'even if you think they're not listening, or can't hear you is to continue to explain to them about why you're doing it and actually what you're doing.' Partly this was about recognising that irritability and aggression affect the ability to concentrate, listen and take in information, and this 'makes them more irritable and aggressive', so extra effort has to be made to keep everything clear by the use of copious explanations.

"They'll probably make assumptions about what you are saying, so I think it's really important to let them know exactly what you're saying, check that they've heard you."

Choose topic in which they are expert (1/28)

Try to engage the patient in a conversational topic of their interest, in which they have more expert knowledge so that

'he's the master of it in a way, and he retains a sense of pride'.

Avoid (3/28)

Past a certain point it was recognised that it was safer to give such patients 'space' and not to 'spend time' with them until they were in a calmer state – or unless needed to de-escalate potential violent situations.

NONVERBAL COMMUNICATION, VOCABULARY AND TIMING

As we specifically asked interviewees not to give us the 'textbook communication skills' few of them mentioned such basic skills as showing attentiveness through posture, facing the patient, eye contact, use of 'mm's' and 'ah's', head nodding etc. The majority of themes were generic to a degree, although there were differences across the symptom domains. These are indicated in the text below, with techniques specific to one domain presented at the end of this section.

Slow pace, patience

Particularly for patients exhibiting apathy and withdrawal (14/28), nurses were keen to 'give someone quite a lot of time' and 'respect the pace at which it is comfortable'. They explained that patients could be cognitively compromised and 'not be working as fast and able to make the connections'. A hurried, rushed and 'pushy' approach was seen as not likely to be successful. Similar comments were made about being patient with hallucinating patients (7/28), particularly in terms of allowing them time to complete tasks. For thought disorder too (10/28) it was necessary to be 'patient in conversation', 'go slowly' and 'give them more time to talk'. One nurse likened being thought disordered to being on holiday in a foreign country where you do not speak the language 'you just have no idea what somebody's saying and they have no idea what you're saying' and noted how frustrating that was and how much patience is required on both sides.

Slow speech

As well as taking things at an overall slow pace, some nurses talked about speaking slowly, particularly with patients who were hallucinating (2/28) and especially with those who were agitated or overactive (7/28) 'not picking up on their rapid flow of speech' and 'being quite measured in how I'm going to respond to them', 'slowing the pace down'.

"I think you need to keep cool and the slow pace. The faster he goes or she goes, the slower you should go, try to calm people down".

Simple vocabulary (5/28)

Avoiding 'medical jargon' and 'technical terms', 'talking naturally' and 'using simple language', because 'to somebody that is hallucinating the concentration span is so small'. The aim was to reduce the burden of 'cognitive work on the part of the client'.

Short sentences (12/28)

Similarly, in order to make misunderstandings less likely, nurses recommended the use of short sentences, again on the grounds that 'the cognition isn't working so well

and the level of concentration and their ability to work out communication is much reduced'. Others expressed this as being 'clear and concise'.

Repetition (9/28)

Using lots of repetition was viewed as useful for the same reasons, so that if the patient failed to understand at one moment because they were distracted, they might be able to grasp what was being said the next.

"Repeat repeat repeat ... I think you should never assume they understand what you're trying to communicate. I think you should take it for read that you're going to have to repeat it. You might have to write it down. You might have to say it over and over again. In several different situations, you might have to get somebody else to say it".

Use silence (2/28)

Allowing long pauses was recommended as a way to elicit some response from certain patients. "Slowly, softly, empathically, sympathetically and allow them time to talk when they're ready and if you need long silences, then you have long silences. It's a tool for your trade."

Quiet, not loud or shouting

Although mentioned for thought disordered patients (1/28), this seemed to be particularly important for agitated/overactive (10/28) and aggressive/irritable patients (9/28). This had a potential 'calming effect' on patients and was considered to help them 'listen a bit more' by requiring them to be silent themselves and concentrate. Doing the reverse, mirroring the loud voice of the patient or shouting was reported as being likely to make patients more agitated, and it was pointed out that it was possible to be assertive without 'raising your voice'. As the following excerpt shows, it was even possible to use this technique during telephone conversations:



"I watched a colleague of mine coach a client on the phone once, they put it absolutely magical, he was trying to help this client deal with the housing, and the client kept swearing at people, and my colleague was just sitting there, reading the paper with his feet up on a desk looking so relaxed, and every now and again he would just, it was like a conductor conducting an orchestra he would just, lower, lower, just like that. And it was wonderful watching the client just moderate his behaviour, to these very gentle interventions from the worker."

However in extreme circumstances then it could be allowable to try shouting:

'if the aggression is at that level that somebody's actually trashing something then you can just shout, stop, and then that can actually help sometimes as well'.

Tone of voice (3/28)

A sympathetic, empathetic and caring tone of voice was mentioned in relation to dealing with upset and distressed patients.

Writing and drawing (4/28)



These were seen as options when verbal communication was not proving effective, or to open a second channel via which information could be conveyed and exchanged. Diagrams and pictures could be drawn, writing down information for the patient to take away with them and look at it when they were able to concentrate or to use as a reminder to do certain tasks: 'if they've got something written in front of them that can help them as well to remember what they're supposed to be doing and when they're supposed to be doing it.'

Less vs. more gesticulation and movement

Movement and gesticulation were other available channels for communication. With thought disordered patients (4/28), instead of giving instructions verbally, a combination of showing what they needed to do with gesticulations might prove more effective: 'you might need to get alongside them and model what to do'. 'Eye contact' and 'facial expressions' could also be part of this process. However for agitated or overactive patients, the nurses advised precisely the opposite, be 'still', 'not fidgeting', 'slowing down movements': 'just don't gesticulate too much or things that can often can raise feelings of agitation'.

"You have to be so un-agitated. You have to be like a block of ice really, like a block of stone, and that's tone of voice, eye contact, where you place your hands, how much you move around, quick movements, the whole bit. You are like this great big boring slab of humanity in the face of this excited dot."

Touch/close vs. No touch/distant

Nurses were cautious about advocating the use of touch. For apathetic withdrawn patients, one nurse suggested that 'sometimes actual physical contact or reassuring physical contact, just by touching somebody's hand or physical touch can be important' however they also acknowledged that 'if you come and sit too close to somebody who's not ready for that, that can be incredibly intimidating'. In relation to hallucinations another nurse mentioned that 'people when they're very psychotic are, probably their spatial, their need for space is probably a little bit larger than normal, not true of everyone but it could be'. Interviewees were more likely to recommend or view touch as positive for patients who were upset and distressed (8/28):

'and sometimes just putting maybe your hand on their shoulder to support them while you talk to them calmly'.

However even here two nurses expressed caution, with one saying this had to be appropriate to the relationship' rather than just the normal behaviour of the nurse concerned, and another saying that 'it's such an emotive thing ... some people don't want to be touched'. When it came to aggression and irritability, they were clear that personal space should not be 'encroached', and patients should not be touched (3/38).

Short interactions (19/28)

Somewhat in contrast to statements about patience, and giving adequate time to people without rushing them, nurses also emphasised the need for brief and focussed

interactions. Perhaps the duration of the interaction reflected its purpose, with task and information seeking/giving likely to be shorter than relationship building and assessment interactions: 'you really have to be very focussed on the task that you're doing, so kind of very brief in your interventions'. Or perhaps it was that even gentle and slowly-paced interactions could still be conducted briefly, for example one nurse spoke about 'small doses' and 'give the patient time' within the same response. Keeping the interaction short was about fitting it to the individual patient, making it 'tolerable for the person', within their cognitive capacity or not adversely impacting on their mental state, for example 'over stimulating' the overactive patient, engendering distress in a thought disordered patient who cannot understand what is being said, or igniting aggression from someone who is highly irritable 'because usually, when people are very irritable, agitated, going on about things actually increases their irritability'. However changing mental state during interaction could also indicate a need for the nurse to change strategy rather than curtail the interaction: 'usually been that when people are very agitated or feeling irritable or aggressive it's usually because they're quite distressed or frightened or disturbed by what's going on around them, or the environment that they're in, so it's usually a sign to maybe change something or do something a bit differently for them, or your interaction with them'. Brevity was also about making the interaction tolerable for the nurse, 'trying to spend a length, any significant length of time with them would probably not work, and I think I would probably end up feeling frustrated', and a pragmatic means to end a conversation that might otherwise have no reasonable end point: 'and listen to them, but not forever because otherwise you're one nurse, or one mental health professional down in the team because they will take you away for the full day'. Some of the nurses spoke about setting these boundaries by giving the patient timings in advance: 'from the outset saying, I'm just going to see you for 15 minutes, and then trying to get into a conversation with them'.

Frequent interactions (15/28)

One way to provide time to patients whilst keeping interactions short was to increase the frequency of contact, 'consistently going back' and 'building up a regular pattern so there is a familiarity there'. Nurses indicated that with this strategy it was necessary to remember the content across contacts, developing continuity despite fragmentation, and continuing (or reinitiating) tasks started during the previous interaction. Frequently going back enabled nurses to check on patients' safety, and could be reassuring for them, developing a sense of security.

Persistence (16/28)

This communicates interest and commitment to the patient, being persistent and not giving up despite any lack of progress demonstrated concern for the patient. Such persistence could be rewarded by the patient starting to respond verbally, 'become open', 'start to trust' the nurse, or 'come out more from her room and joining activity groups'. Constant persistent offers of contact, without 'getting exasperated', enabled nurses to seize on those occasional moments when the patient concerned was receptive. Not giving up over the longer term was also important for aggressive or otherwise difficult and disruptive patients. "It will take dips, and just not to give up and try other ways or restart again. Trying to build that relationship and always being open with them after an aggressive period, and explaining things to them after a period where they've been quite aggressive."

Aggression/irritability

Choose language (4/28)

Just a few hints were given as to how to modify language to deal with irritable patients. Saying 'you sound very grumpy' was seen as more acceptable and less likely to give offence than accusing someone of being irritable. And talking in terms of 'we or us' was seen as more likely to lead to a resolution than 'me and you' or just 'you', as this makes people feel less isolated, for example 'it would be good if we could all come to an agreement or an understanding about how we can make this situation better or different or less irritating for you, or less dangerous and frightening for those of us here'. Sentence and question construction could also be undertaken in less rather than more confrontational ways:

'I can go in and say why did you hurt the nurse, instead of that it's like I was kind of saying what happened that the nurse got hurt, tell me how that nurse got hurt?'

Non-verbal non-threatening (14/28)

Nurses recommended the use of 'open hands, open gestures', and refraining from any gestures associated with ordering, commanding, hierarchy and authoritarianism, such as: 'wagging your finger', 'staring people out', 'pointing at people', 'folding arms' and 'standing with hands on your hips'.

EMOTIONAL REGULATION

Warm and genuine concern for patients was critical to all interactions with patients, and was presented under 'moral stance'. In this section we present other material related to the emotional experience, presentation and self-regulation of nurses. Most of this ran across all symptoms domains, but potential problems seemed to be most acute around nurses' reactions to aggressive and irritable patients. Low levels of negative emotion or responsivity were deployed by nurses as a dampening mechanism that provided the social environment patients seemed to require in order to settle and reduce their psychotic symptoms.

No anxiety (26/28)

Not being frightened or scared by the expression of psychotic symptoms, whether they be thought disorder, hallucination or whatever, instead expressing to patients a calm, confident, knowledgeable response, such as 'I've met a lot of people who have these experiences, and it's almost like, I'm not frightened by you having this and I've come across it before'. Being 'calm' and 'relaxed' was also important in the face of agitation and overactivity, both of which could be made worse by tension and anxiety in the nurse, indeed one nurse said it was not a good idea mirror patients agitation, or 'be drawn into it'. Nurses also had to be able to emotionally 'contain peoples' distress', by being calm, rather than 'feeding into situations, making a drama out of it in terms of someone's disclosed something and it's, oh my God that must have been terrible, how dreadful'. It was important to convey the message that the nurse could 'tolerate' the patient's distress, 'being calm and receptive', as 'quite often distress is related to something that might well be very difficult to hear as well'. Across the psychotic symptom spectrum, 'seeming relaxed around the experience' was said by nurses to be likely to 'help reduce it', in addition modelling 'good behaviour' for the patient by communicating that you are 'comfortable', 'confident' and 'secure'. Acute anxiety can warp nurses behaviour towards certain patients 'they are terrified, they're paralysed by her agitation because they know anything, anything even slightly provoking will cause this massive explosion. So it makes people not be honest with her, or give in to her very quickly where it's not necessarily the right thing to do, so it's hard'. In crisis situations, where patients are shouting and waving their arms around, it is quite natural for nurses to be frightened, however it was reported to be better if they 'model a more effective way of dealing with it and be able to stay calm ... and to emotionally self-regulate'. It could take nurses years to learn this skill, but once they could 'channel any anxiety or navigate that anxiety into quite a peaceful state', 'steady', 'appear unfazed' and 'in control', they were more likely to be successful in de-escalating such situations. However this was found to be extremely difficult by some, and one nurse reported that with one terrifying patient 'it was actually a supreme effort to not make my fear of him very obvious'. Nurses' anxiety was not just about patient behaviour, it was also about failure, particularly failure when on display in the ward day room with patients and trying to interact with difficult and challenging patients, a feeling of 'pressure to do well'. Not being anxious in this situation meant being able to take the risk, and being willing to publicly fail.

No frustration or irritation (25/28)

As with anxiety, reducing the expression of frustration was said to be important across the full symptom spectrum, but was particularly relevant to dealing with aggressive and irritable patients. The sheer amount of time and energy it takes to accomplish a

simple task, for example obtaining a patient's menu preferences for the next day when he or she is thought disordered, can generate considerable frustration. Such responses could generate a kind of vicious cycle within the interaction: 'people that spend too much time with people that are thought disordered become irritable and start to then reinforce that irritability onto them which makes them more thought disordered'. There were similar risks of getting 'irritated or tired around someone who's overactive', or frustrated around the long term struggle that can be required to engage with the apathetic and withdrawn patient, or get them to do something, 'not taking offence if someone says, I don't want you to be here, please go away or in slightly more direct terms than that'. In these and other similar situations it was considered important not to 'take things personally', but instead understand that 'what you're seeing is likely to be symptoms of their illness'. In this way it was possible to resist the temptation to 'pressurise', 'cajole' or 'rush' patients. When patients are being angry for what seems like no good cause to the nurse, it can be difficult not to get irritated and angry in response. One example was given where nurses responded emotionally to racist abuse, and it was stated that 'fighting irritability with irritability is just not going to work', instead this was likely to 'escalate the whole situation' and was considered to be the 'ultimate unsuccessful technique'. In these already tense, difficult and threatening situations, nurses had to pull off the feat of monitoring their own emotional responses, being 'careful about how the person's made them feel' and refraining from 'antagonising them more' by getting 'inadvertently into anger and aggression yourself'. Examples given were 'losing your temper', 'shouting back', and 'being rude back', with one nurse warning 'just be careful of all of these kind of things when people are angry, it can bring out all sorts of demons in the other person can't they?'

Optimism (7/28)

"If you're feeling optimistic then it's more likely over a period of time that that will rub off on the patient. Whereas if you're going in there and you're thinking there's no hope for this patient, then the likelihood is that nothing will change."

Maintaining an optimistic stance was judged valuable, and to accomplish this, nurses had to generate their own belief that the person could improve. This was easier if the whole ward team were 'going in there optimistic', communicating and instilling hope for the future.



GETTING THINGS DONE

When a person is acutely psychotic, they can be very difficult to manage. It is the nursing task to make sure that deluded, hallucinating, overactive, agitated and sometimes distressed people get sufficient sleep, get up in the morning, wash and attend to personal grooming, wear appropriate clothes, eat and drink sufficiently, etc. In addition attempts have to be made to build a relationship with them, foster social contact between patients, engage them in organised activities. At the same time nurses have to ensure that they take their prescribed medication, don't leave the ward without permission, see various visiting professionals such as psychiatrists, avert or diffuse arguments between patients and prevent them from harming themselves.

Suggest, not order (24/28)

"But if you're just going in and using one blanket expectation for all and not really thinking about why it might be hard in one way for one patient and hard in a different way for a different patient then actually I think that, that means that they're maybe only complying because they may be frightened not to or intimidated into complying and actually it probably doesn't help build the relationship and ... mean that they can achieve their next goals. So, yeah the inability to think about them differently and individually and work out what works best for that, I think that means that you're more likely to get resistance and more likely to get people who maybe just comply because they're a bit afraid not to."

The nurses reported that suggestions were better than dispensing orders, because they were more likely to elicit cooperation and helped to grow the relationship with the patient concerned. So, instead of telling people to get up or wash, the verbal formulae for 'putting across a suggestion' that were more likely to work were: 'it's 8 o'clock in the morning, are you going to get up now, do you want to have a shower?'; 'this is usually the time where we do this and do you want to do that?'; 'would you like to eat, would you like a change of clothes?'. This was the opposite of 'being bossy', 'pressurising' people, being 'too domineering, or taking control, telling people what's good for them', telling them 'what to do'. Even asking could be tricky on occasion, as 'if you ask them to do something that just by the mere fact that you're asking them to do something they will become irritable'. Critical approaches, coupled with unrealistic targets for what patients could accomplish, with an undercurrent of anger and irritation from the nurse, were not likely to be successful, and might 'provoke patients' or evoke 'resistance'. Worse still was 'shouting', 'manhandling', 'threatening' sanctions such as withdrawal of leave, and physical force such as 'grabbing by arms and dragging and that's just, that's just terrible, trying to force people into things'.

"Unsuccessfully has been to try and take over, and not really allowing the patient to think but sort of imposing a plan on them ... very unsuccessful. I can think of an occasion where I did get very, very caught up in the patient's anger and abuse, and she was extremely agitated ... I'd rather it hadn't have happened, because it was totally unproductive and it made me really think, I'm never doing that again because it didn't make me feel any better, it didn't make the client feel any better, it didn't achieve anything."

Give reasons (15/28)

"Things are really bad at the moment but it's really important that we keep you hydrated, we keep you with some food because we are working to really help you and improve things for you. It's important that we keep you physically fit as well because things are really difficult at the moment. So you'll be trying to persuade them that we've got to try and do something about their physical health as well."

To generate motivation for and compliance with necessary tasks, nurses would give reasons and rationales for the behaviours they wished to elicit from patients. So the need to take medication and what effects and advantages it might have would be freely discussed with patients, as would the benefits of eating regularly, drinking enough fluid, having a bath, etc. Some really fundamental and obvious things might need to be spelled out for the patients, such as 'eating and sleeping can help you cope with this challenging, distressing situation', and getting dressed might help because 'keeping up your everyday activities is going to help you through this, whereas if you let things slide you're going to feel worse'. In other words, explaining exactly why the task is important and what will be achieved by doing it, and how that will help the person restore a normal pattern of activities and shape to their day: 'showing them the link between the physical and the emotional and how they all interact and interplay with each other'. One nurse referred to this operational psychiatry as 'some kind of talking economy', with desired behaviours being purchased by nurses through interactional investment.

Be flexible (21/28)

"If it's going to bed and you're really wired and irritated, it's unlikely you're going to be able to go and fall asleep. So maybe there's some middle ground that you can find where you go, well maybe you're not going to go to sleep, but maybe you can go and read in the, not read probably, listen to music on your headphones in the smoking room. I don't know, I just think rules and tasks are only of limited use, they need to be meaningful for people."

As part of the discussion process, the patients point of view about the task can be explored, so that they can feel heard and valued, and so that the timing or precise content of the task can be adjusted to suit their wishes. This generated a participative relationship 'so that you're not just imposing something, but they're actually taking part in it'. Talking about the task also allowed the identification of factors that might be preventing the patient from doing it: 'I guess I skirt around the outside it a lot, to see what it is that's blocking it'. Understanding the patient's reasoning process meant that nurses could sometimes find workarounds, or ways of both getting the task done and satisfying the patient at the same time, reaching 'common ground'. Flexibility could also be shown by giving a degree of choice to patients: bath or shower; tea or coffee; now or in half an hour; with me or with another nurse, etc. Giving such options meant that the interaction was much less likely to be taken as or descend into an argument, and in addition the task could be made more attractive by offering different foods if the patient wasn't eating, or varied bath accompaniments (shower gels, soaps, towels) if they were reluctant to wash. Negotiation could also be a valuable tool, offering a range of potentially more desirable options in return for a degree of co-operation. Care had to be taken, however, to only promise what could actually be delivered, otherwise the longer term situation could be made worse.

"If we've got somebody who doesn't like sleeping in her bedroom when she experiences certain types of hallucinations and she prefers then to sleep on the

mattress on the floor. And that's fine, I think, for that period of time until the woman or the person then feels safer and you, I wouldn't necessarily try to change that."

Break down task into small steps (13/28)

"I find it's probably simpler to break down the task into simple little bits. And so instead of saying, OK this morning, well what we intend to do is to either, maybe get your laundry done, it's probably easier to say, could you just put your dirty clothes here. And then from there, can we take them to the laundry room? And then from there, washing powder, so just breaking the task into little bits, and trying not to get into any more complex conversations during that time, that would distract them from the task."

Taking any task in 'clear, slow steps', or 'bit by bit' was thought to be advantageous, as 'giving them too many things to do or too much pressure' was unhelpful. Another example given, in addition to doing the laundry quoted above, was taking a bath, which could be broken down into collecting the towel and toiletries, going to the bathroom, running the bath, getting in etc., or going to bed broken down into turning down the sheets, taking off your shoes, then the rest of your clothes, putting on the pyjamas, etc. This mode of approach meant that it was easier for patients to understand what was required and to succeed at what they were trying to do. One thing at a time meant that the patient 'did not have to remember a sequence of tasks' and cooperation was thus less cognitively demanding, whereas 'anything too complex is just going to be bound to fail'. Some tasks could be broken down into smaller disconnected bouts of activity, in recognition of the fact that patients might not be able to concentrate over a sustained period. For example conducting a systematic mental state examination or rating scale could be done over several short sessions over the course of a day, rather than over a single continuous period of time. Another sense of 'step by step' as mentioned by nurses was that of gradually increasing expectations about what patients would do, as they recovered from their acute symptoms: 'so it went from the non verbal, well it went from the isolation, to the non verbal, to watching TV together, to talking, to coming out and eventually eating in the dining area ... it was a very gradual and a slow process over a matter of, couple of months'.

"To make a bed for example, and to ask them in terms of helping me precisely what I want them to do, so it's not just, oh help me make the bed. It's, can you get the pillow out of its pillowcase? Can you put the pillowcase on? Really breaking down tasks and making it very simple for them to be able to understand and achieve, and, yeah so very focused, very specific and probably not anything that's going to go on for too long."

Avoid, defer or postpone tasks (13/28)

Somewhat similar to choosing the right time of day, there were times that it was better to avoid when trying to complete a task with the patient, for example when he or she is especially agitated, irritable or upset: 'just leave the tasks that I know are going to cause conflict' or 'calm them down before you actively involve them in things'. So non-essential tasks could be avoided and postponed to later in the admission, and even essential tasks such as getting the patient to eat and drink could be carefully timed to maximise the chance of success: 'but they might be hungry later on and I will be able to give them some sandwiches, some toast, some biscuits, or whatever is available'.

Maximise task choice and attractiveness (16/28)

Ordinary everyday tasks can be made more attractive with some care and preparation. For example one nurse described making bathing easier for patients: 'if you say, I've run you a bath and I've put lots of nice soaps in it ... I've got this really nice new bubble bath and I've got some nice clean towels'. This approach to improving patients' hygiene was recounted in almost identical terms by several of the nurses. Alternatively if the important thing is to get the patient engaged in any activity, then having a wide range of things to do can assist in finding something that he or she can respond positively to, 'just offering something that might interest them' and 'you've got to offer them choices'. "I had somebody who was very withdrawn, wasn't interested in any communication, but had a dog and just trying to sort out a dog has made him come out of the shell and from the little things, the door will open".

Prompting (10/28)

Being with the patient while the task is getting done, and giving gentle reminders and prompts, almost like a form of coaching: 'shall we do this now'. Even more basically, some patients might need reminders to continue to eat and consume the food on their plate, or drink what is in the glass in front of them on the table: 'it's trying to gently remind them to keep on course with the task they're doing rather than going off all over the place, without pressurising them, to gently remind them oh, you were having your dinner'. Such prompts are 'just a reminder to bring somebody back into the here and now, rather than whatever else is happening, the other distractions in the persons mind'. As an alternative, a written list of instructions can be provided: 'if they've got a simple task like making a sandwich, if you write it out in five statements ... they can keep going back and looking at it, and seeing what they're supposed to be doing'. The prompts and reminders help patients stay on track when they are overactive and their thoughts skip from topic to topic too fast, or when thought disordered or distracted by hallucinations.

Positive feedback, encouragement (13/28)

Recognition of the difficulties patients experience and praise of their progress towards accomplishing a task, were critical ways to keep them motivated to complete the task in hand: 'it's positive reinforcement, you do something good, you make that person feel good about what they do, I think that works'. Constant reassurance that they are doing well, coupled with acknowledgement of the effect their mental state has on their ability to do such mundane tasks. Highlighting their abilities and successes can help energise patients, as 'even if it's only a very small goal, to the patient it might be really, really big'. All this has to be accomplished without being patronising, communicating any sense of superiority, of belittling the patient in any way, instead being 'very appreciative of how difficult it is' and expressing gratitude for their efforts and work.

Assist, do part of the task (6/28)

Instead of abandoning patients to complete the task themselves, once they had agreed, nurses suggested that with some patients it was a good idea to render further assistance: 'the main thing would be to do things with them'. Finding the right level of assistance to provide was considered to be a 'fine balance between being caring and encouraging people to take action without actually taking the action for them'. Starting to give assistance also ran the risk of eliciting passivity from the patient and frustration from the nurse at the slow pace of progress, with one nurse confessing 'I would probably end up doing all the things the agitated person should be doing ... so my

strategies are pretty useless'. Of course it is somewhere between very difficult and impossible to judge what an acutely psychotic patient is capable of doing at any one moment, hence nurses move forward step by step on a pragmatic basis, trying to elicit from the patient the most involvement they can.

Assertiveness (18/28)



"I mean it's a very difficult thing to do but it's something again, I'm sure in Mental Health Services we get heavily criticized for, that somebody was too agitated to eat or drink for three days. And obviously that's going to have such an impact on their physical well being. So I'd have no qualms at all about restricting somebody's access, stopping somebody, sitting them down, trying to encourage them very strongly to have a drink. Obviously to take medication if that was necessary which it probably would be. Try and get them to have something to eat."

Despite nurses' reluctance to order patients to do things, and their desire to suggest action, give rationales, be flexible and search for consensus, there were occasions when it was necessary to be more forceful. This was typically in relation to giving prescribed medication, but also about ensuring patients drank fluids or ate some food (preventing dehydration or malnourishment), or kept clean enough not to become objectionable to other residents on the ward. This might mean being more assertive, instead of 'shall we?' statements, being 'prescriptive' such as saying 'we will', 'we are' and 'it is going to happen' becomes the format of communications: 'just saying, you should have a shower because you really smell and just doing that, and then it'll just happen, and people can sometimes really respond to that'. Constant reiteration and request, 'keep going on about it', is another strategy, even though 'it can feel a bit like a broken record in terms of having to ask people to do things and insist'. Explanations or rationales as to why it is necessary to eat or drink yield to descriptions of what will happen if the patient does not co-operate. Alternatively, nurses may try to use their relationship with the patient as leverage: 'take it for me, or trust me, I really think you should take this medication'. Instead nurses might quietly ask another patient to have a word and encourage action, or allow confrontations over personal hygiene to take place during patients' meetings on the ward, thus beneficially utilising peer pressure. If something really important is at stake, then several staff might be assembled in a show for force to clinch the issue. Or being more assertive might mean intruding on the patients personal space in order to overcome their withdrawal, touching them in

order get them to drink or take medication, maybe even guiding the cup or the tablets in their hand up to their mouth, thus one way or another 'forcing the issue'. Nurses said that to do these things made them feel 'uncomfortable', uneasy and 'dirty in a weird kind of way'; nevertheless they accepted that was a 'moral responsibility' to 'cross that threshold'. It does not mean that gentleness and the search for co-operation were abandoned completely. At every stage the patients' difficulty was verbally recognised and appreciated, their smallest of moves towards co-operation met with warmth and encouragement, respect for them maintained, and every step of increased assertiveness by the staff taken with deep and overt reluctance. Nurses experienced the most agonising dilemma as keeping patients clean. Food, fluids and medication were a given and seen as urgent issues of high importance: 'if somebody really needs to eat because they're dangerously unwell, then I think sometimes your tactics you use have to be much more forceful really, in terms of how you, maybe physically encourage somebody to stand up and walk with you to the kitchen.' However cleanliness was more difficult, as 'how much do you infringe someone's human rights to get them into the bath?' One nurse told of seeking legal advice on the issue for a patient who was agitated and overactive and wouldn't let anyone near her, but who was menstruating, with the result that she was restrained and given a shower.

"Right this is what I see at the moment, we feel as a team that this might help you and this is what we're going to do. So it's being very directive ... taking control of the situation because they are not able to do that for themselves."

Delusions

Semi-collusion for greater good (3/28)

Where tasks were really important, such as delivering the food/fluids/medication trio, some nurses were willing to lean a little bit towards colluding with patients delusions, by not challenging them, not taking a position on them, or expressing neutral comments that were ambiguous as to whether they expressed understanding or agreement. In other words bordering on allowing the patient to believe that their delusional system was accepted to some degree. This was recommended with extreme reluctance: 'it may not be a, the intervention that people would recommend, but sometimes you have to go down that route, I think, just to get the person, who is pretty deluded to work with you'. One example given was of a patient who believed he was a member of the royal family, but who hadn't washed for some time. The nurse concerned said he did not believe royalty would allow themselves to get so dirty that they smelled, instigating the patient to have a shower.

"If you're trying to achieve a task and the task is important, so if it's something to, for instance, trying to get them to, let's say, take their medication for one thing. Then if whatever their delusion is, and how they're expressing it, if it doesn't pose any danger then, in a way, not acknowledging it but going along with them, just nodding and saying, OK, just for the short term, for them to achieve that task."

Thought disorder

More gestures (5/28)

Instead of using language, which these patients can find difficult to understand and process, nurses suggested that desired tasks could be modelled, indicated, or described through gestures in order to enhance successful communication:

'being more visual and demonstrative about it'.

TALKING ABOUT SYMPTOMS

This section includes everything the interviewees had to say in relation to talking with patients about their symptoms, or interacting with them in ways to reduce their symptoms. Although there was some overlap between domains, we present this material separately by symptoms, as there were specific nuances to these approaches that required careful description.

Every one of the interviewees mentioned the value of medication, either regular prescriptions, as required doses, or in some cases coerced rapid tranquillisation. This is not explored in detail below. They also mentioned a number of formal psychotherapeutic approaches as applicable, including: cognitive behavioural therapy, solution focussed therapy, hearing voices groups, relaxation training, anxiety management training, anger management training, motivational interviewing, systemic family therapy. As these are all well described in textbooks, and the interviewees did not add any detail about their specific application to acute psychosis or inpatient work, these have not been further described. However there were a number of techniques the nurses did describe which would be claimed by one or other of these therapeutic approaches. As these were described in detail and repeatedly by nurses, with specific applications to acute psychosis or inpatient work, these are described below.

Apathy/withdrawal

Hearing and respecting the experience (9/28)

The emphasis for apathetic and withdrawn patients was not so much the endeavour to get them to describe it, but instead to observe, recognise, acknowledge, respect and try to understand it. This meant not pushing too hard, tolerating silence whilst still spending time with the patient. Patients could still also be asked about their feelings and experience: 'I would look at actually getting them to describe their feelings and how they feel, what's going on for them within'. Respecting that experience involved not putting such patients under pressure 'to be what they are not' by an approach which is 'too animated' or 'forcefully' putting them 'in social situations that they might not handle at that point'. It also meant not 'ignoring' the apathy and withdrawal as if it were not there, but talking about it, 'acknowledging how they're feeling' and approaching them for durations and activities that they could reasonably tolerate. Several of the nurses spoke about apathy and withdrawal being meaningful behaviours with reasons, and stated that 'you had to acknowledge that' and try to 'understand the position they are in' because 'it's always a different reason for why they are withdrawn'.

"I think it's important, if they are withdrawn there might be reasons for it, and you need to understand what reasons they are. They might be scared, they might be worried about any environment, they might not know what's going on, and so you have to respect that."

Mutually explore causes (7/28)

Nurses indicated there were 'hundreds of reasons' why someone might be in this condition, and in addition to acknowledging and respecting it, it was necessary try to 'work out from them why or explore the reasons with them, why they're feeling the

way they're feeling'. One way of getting to this information was by suggesting a task or activity to them, and then exploring their feelings about it or reasons for declining: 'say think about what might be beneficial, exploring why they haven't done that, exploring why, if there've been concerns why do they think other people are concerned'. Alternatively nurses might offer the interpretation that their experience is a 'symptom of the illness they may suffer from'.

Negotiating and agreeing a care plan (7/28)

Nurses said this was far preferable to using force or trying to coerce the patient to do things. Instead they advised negotiation, 'forming a plan with the patient' and they argued that this approach based on 'kindness' worked better. Such a plan had to be realistic in terms of what was expected from the patient given their mental state. Such agreements 'to try to do something together' could not necessarily be reached quickly with apathetic and withdrawn patients. One nurse described several days of trying to maximise and increase contact with such a patient who was virtually mute, in an unwashed and dishevelled condition and spending all of her time in her bedroom. By utilising every possible opportunity, eventually the patient spoke to her, and once communication was established a care plan was written and discussed with her, which she agreed to. Only then was it possible to get her into the bath on a consensual basis: 'just that relationship that existed between me and her enabled me to actually succeed in that'.

Structure, routine and purpose (5/28)

A number of different means to accomplish this were reported, including establishing a reward structure of some sort, utilising desired activities such as going for a walk, out to the shop, leave opportunities or progress towards discharge. Alternatively plans and timetables for the day could be agreed, diaries of activity kept so that progress can be made visible. Rating scales could be used and the results placed on a wall chart in the patient's room for the same reasons.

Step by step (6/28)

Managing a slow, staged build up of activity and social engagement on the part of the patient. One nurse described spending two months working with a patient who initially was completely isolated and could only communicate nonverbally, through gradually venturing out of their room to eating in the dining room and watching television together. Another nurse referred to this a 'graded exposure ... which can sound very technical, but it's just getting them to do little bits at a time, and they can see that they can build up to the goal'.

Hallucinations

Hearing the experience (24/28)



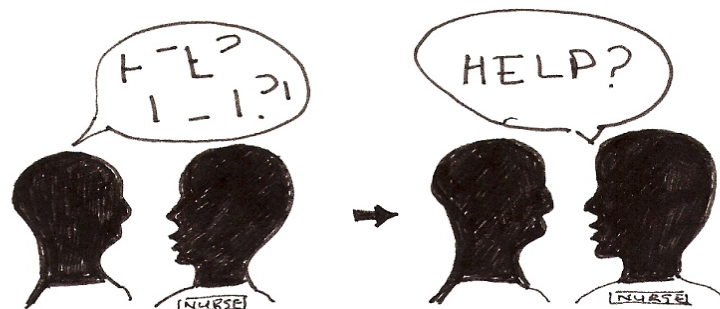
The patients experience can be explored by observing the impact voice hearing has on them, noticing their distraction, their talking back to the voices and their body language. However their experience can also be explored by asking such questions such as: 'how loud', 'how long does it last', 'how many voices', 'what do they say', 'how frequently does it happen', 'is it saying anything about me', etc., in order to 'try to get to the heart of their experience'. Some nurses used structured questionnaires in order to systematically understand what patients were experiencing. That understanding could extend into interpretations as to what the hallucinations might represent for the patient, such as 'some bereavement that they didn't address and manifesting itself at some level', or 'a reflection of some kind of relationship they've had'. Conversations might

have to be timed to periods when the patient is not actively hallucinating, or the patient might not wish to talk about them, in which case this needs to be respected.

"In some ways, I guess it's tied in with the talking about what's going on and the thinking level with the hallucinations as well, and sometimes I'll just sit down with somebody and we'll have quite, for want of a better word, crazy conversations about whatever's going on that are very left field, and just about, what that persons beliefs are, and just exploring the terrain of, all right, so you think this is possible and you see this stuff, and the implications of it and the symbolism of it."

Hearing the effect on the patient (17/28)

The interviewees stressed that it was important to be calm, accepting and not frightened of these strange experiences related by patients. Patients themselves could find their hallucinations frightening, so to hear their experience calmly 'gives people some relief', and ensures they are 'not alone in their personal hell'. The voices patients hear can be persecutory and abusive, causing them great distress. Visual hallucinations could also be frightening, with one nurse describing a patient who was reluctant to go to bed as he saw eyes all around him and thought he was a 'sitting duck' in bed. Nurses recommended talking with patients about the impact their voices were having on them, in a calm and confident manner, as a first step towards offering help. Some nurses suggested concentrating on the emotional impact of the voices more than anything else, as 'feelings are very real and the consequences of the feelings are real'.



Hearing to assess safety (9/28)

Hallucinations could pose safety risks for the patient or those around them. Examples given included 'voices that are telling them that the food is poisoning them', becoming so distressed by the voices that 'they are a serious risk to themselves', be unpredictable, 'suddenly lashing out and attacking' someone, especially in the case of auditory hallucinations that command them to do things such as harm themselves or others: 'telling them to jump off a building' or 'telling them to kill such and such a person'. Nurses needed to hear about and explore the nature of these hallucinations in order to work out how best to help the patient and keep everyone safe.

Respecting the experience (15/28)

Respecting equals openly talking about it and acknowledging its impact on communication, the disruption, distraction and difficulty that the experiences causes for the patient: 'you've got to acknowledge it and make it real, although you can't experience it you've got to act as if it's happening in the room'. Not respecting meant

'ignoring the hallucinations and talking about something else' or saying things such as 'snap out of it' or 'threatening them ... if you respond or talk to the voices, that means you stay in the hospital longer'. Totally dismissing the patient's experience was also not respectful, saying things like 'you have got an illness and these are all not real and let's try and not talk about them', or it's 'all tricks in your mind, it's all in your head', or 'it's just not real, it's not happening' This 'invalidates their experience', adds to the person's distress, simply doesn't work, is not helpful to the patient and pushes them 'away from services'. Such approaches were said by one nurse to be linked to biological medical model that sees hallucinations as essentially meaningless and irrelevant psychotic phenomena. "I think people can be quite dismissive of people who are experiencing voices and think that there's no point, that actually somebody's too unwell for you to try and engage with them and I think that's thoroughly wrong. I think it doesn't matter how unwell or psychotic somebody is, you can, there's a glimmer of being able to engage with them on some level.

"If put on the spot by a patient, instead of contradicting the patient's experiences, nurses recommended simply saying 'you may see, hear or smell so and so, but I don't',

thus acknowledging their experience without affirming or confirming it, or the beliefs that are attached to it. Colluding with the patient's hallucinatory experience, perhaps by agreeing with their interpretation of it, was not seen as at all helpful or respectful.

Stress management (6/28)

Several nurses identified a link between stress and the experience of hallucinations, and suggested 'identifying the external stressor', taking action to ameliorate or remove it, and teaching relaxation skills or deep breathing exercises to the patient experiencing the stress in order to reduce their response to it:

'trying to get them to relax and be able to switch off anything which is happening internally ... like a low level meditation, and however they got themselves there whether it was through music or doing relaxation techniques, I'd always aim to try and get them to, where they'd be able to have no internal talk or hallucinations happening'.

The focus here would not be so much on the hallucinations themselves, but 'why this has happened at this time in your life, what do you think is going on?'

Negotiating and agreeing a care plan (6/28)

The nursing response to hallucinations needs to be negotiated with the patient concerned. Some are not distressed by the experience, and do not want the nurses to do anything, others wish 'to ride through the experience and discuss it afterwards'. By discussion and negotiation, strategies that patients have used successfully in the past can be supported by nurses during the current admission. With some patients it is possible to agree a graded response based upon the intensity and severity of the symptoms, with an agreement as to when additional medication will be used.

Distract (15/28)

Patients could be distracted from their hallucinatory experiences by 'talking about something else or doing something else', and suggestions included 'talking and walking', 'watching TV', 'listening to music', having a 'game of pool' and 'reading a book'. It was noted that patients are very individual in what they find helpful in these circumstances, so the strategy has to suit them or be discovered through trial and error.

“So I think there are times to talk about hallucinations and how they affect you but I think that engaging in different activities like playstation, football, their interests, getting them to socialise with other people ... can be really useful.”

Bolster coping (10/28)

In addition to distraction techniques, nurses mentioned the use of earplugs as helpful to some patients, asking the voices to go away for a fixed period of time, or telling them to go away. Being in a room with others can help some patients with their hallucinations, but makes others worse. Normalising the experience helped some by reducing their anxiety, letting them know that it is ‘not uncommon’ to hear voices.

Casting doubt and challenging (8/28)



Nurses described several ways of gently (and sometimes more strongly) challenging patients experiences with voices. For example, oblique reassurance, not directly contradicting what the voices were saying, but alleviating concern nevertheless. The example given was of a patient whose voices had told him police and gypsies were outside wanting to get him, to which the nurse responded ‘well, there aren’t any in here at the moment, are there?’ Similar example was given about how to respond to a patient experiencing persecutory voices, with the nurse talking ‘to really reinforce their own sense of self and who they are and know they’re not this most appalling person which the voices are trying to convince them that they are’. One nurse described using one sense to cast doubt upon the hallucinatory sense. A patient was seeing snakes all over, and was encouraged to touch the floor and the walls, ‘so they could feel the solidness’ and realise that they weren’t there, getting temporary relief. Others spoke about openly doubting what the voices were saying, or their reality, by remarking gently on how strange the experience was or occasionally, in appropriate cases, direct authoritative contradiction could bring the patient some relief of anxiety and perplexity.

Delusions

Acceptance and listening (18/28)

Nurses responses reflected the fact that patients had a need to talk about their delusions, ‘so giving them that space to talk about them, and to feel that you’re actually listening to them I think is very important’. This importance to listen derived from the fact that ‘for that person their world is real, what’s happening to them is very real’. Many nurses enjoyed or were fascinated by patients strange ideas about ‘what was happening to them, their family, the government or the country, ... so I like listening’. One nurse gave the example of a patient who believed he was a member of the Royal Family (who had even had an official card printed for him and had on one occasion tricked the Police), ‘and he told me everything about it ... and nothing that he said was true ... but talking to him about what he believed to be the truth built a relationship’. Another remarked that ‘sometimes it just pays to be quiet and listen and see that stuff come past’ after relating the case of a patient who had ‘grandiose beliefs about his part in the world and the Iraqi conflict’ and spent all his time ‘shouting his beliefs at me’. The interviewees also recommended attending carefully to the emotions engendered by the delusions, mentioning fear, elation, anger, distress and upset as possibilities. Exploring those delusions was not always just a matter of passive listening. In addition it required nurses to ask about how the delusions started, how intensely it is believed, what sense they make of it and how it relates to their background, upbringing and culture. Such enquiries could be quite extensive, as delusions were usually part of a whole belief system that could take time to unravel and understand. In order to make this telling safe for patients, it was necessary for

nurses not to leap in with contradictory evidence or identify glaring holes in the argument, instead listening with 'attentiveness', 'respect' and 'not disagreeing with the delusion, but maybe thinking about the effect of the delusion on somebody'. Seeking to 'pick holes in them' or 'show they are wrong' during conversation 'is going to have an atmosphere of threat to it' and is an unsuccessful strategy, as 'we all hold our beliefs strongly and defend them'.

"Just taking the heat out of them by listening, and respecting the emotional impact of them is a good way to take some of the sense of isolation away that comes with thinking differently to other people."

Explore to understand the person (16/28)

Accepting and listening to delusional material was a way to generate a deeper understanding of the patient and their experience. Nurses spoke about this as getting to grips with the 'texture' of patients delusions, how they all 'link together', what the underlying 'concept' or 'symbolism' might be, 'tuning in to the underlying feelings', 'learning what it actually means for them' and understanding how delusional systems may have a protective function. Occasionally this level of understanding was capable of generating interpretive insights, linking delusional material to the past or current real experiences of patients, 'making sense of it' in ways that could sometimes be shared with the patient concerned.

"It's to not necessarily just chuck it in the medical box as a symptom, so therefore we are, or down medication, but to try and unlock it really. What might be the idea, why are they experiencing that? Where's that come from?"

Explore delusions to assess risk (7/28)

Interviewees realised that delusional beliefs had the capacity to be linked to actions that risked the safety of the patient or others. They therefore specifically explored the potential for such actions to occur. One nurse gave two clear examples of this. In the first case, a patient had delusions about a woman living in the flat below, that she was making noises that were 'threatening to him or sexual towards him', and the nurse explored what contact the patient had with her, and asked what was the likelihood he was going to act on those beliefs and in what ways that might be. The second example was of a patient who believed he was on a mission that meant he should jump out of a third story window, and the nurse explored how important the mission was, and whether the patient was making any plans about beginning the mission.

Monitor delusions for incorporation (9/28)

Occasionally nurses get incorporated into patients' delusion systems in a negative way, becoming part of the conspiracy against them in some way. This could result in patients becoming hostile and antagonistic towards the nurse concerned, and when this did occur, care had to be swapped to other nurses who were not incorporated in the delusional system in this way, because contact could lead to the patient becoming distressed, or in extreme circumstances, violent. Nurses suggested this could be averted by 'constantly checking' with the patient, 'being mindful' and evaluating 'how you are perceived, how you are seen'. Sometimes it was necessary to explain in great detail why you wanted to ask certain questions before asking them, or maybe even checking with the patient first whether you could ask them, so as to minimise and feeling of threat or loss of control. Staying 'neutral, professional and appropriate' was important, as was not insistently arguing with them that their delusions were false.

Don't deny or dismiss (23/28)

The nurses were generally agreed that it was not helpful or successful to deny the delusion, 'shout at the patient saying it was not real', or disrespectfully dismiss it, 'belittling' them: 'oh don't be so stupid, that's not true', 'that's total rubbish' or 'it's just your mental illness'. Doing this was said to 'completely break down any sort of relationship', sometimes make the patient angry, turns the nurse into an 'adversary' and 'can make the person stop communicating'. Alternatively, with someone who is 'fragile and vulnerable or where the delusion is particularly sensitive or protective of patients' emotions, a denial can 'shatter' them, make them 'distressed' or precipitate 'depression and possible self-harm attempts'. In addition not listening 'doesn't really take you anywhere', prevents proper understanding of the person, and a correct assessment of the level of risk.

Gently question, cast doubt (18/26)

Introducing questions or doubts about the delusional beliefs could be done and might be helpful. However the nurses indicated that you first needed to have a good, trusting relationship with the patient concerned, and that the strongest and most central parts of the delusional system should be left alone whilst doubt is introduced around the edges, with less strongly held and perhaps less emotive beliefs. This work could not, therefore, easily be done early in the patient's admission before confidence in the staff had been established, the delusional system was thoroughly known and good relationships formed. At this point, slightly challenging questions (not direct contradictions) could be introduced, say through expressing puzzlement about the gaps between the delusional belief and the evidence, or gaps in the patient's explanations, such as 'when did they do it', 'how did they do it', 'why did other people do this', or by suggesting alternative explanations, or by getting them to test the beliefs out. These interventions should be targeted at 'little points of movement' or 'ambivalence'.

Directly challenge the delusion (9/28)

A smaller number of nurses suggested that there were occasions when this could be helpful. When a delusion was linked to an intention to harm another person, then a stronger challenge was absolutely necessary. However another nurse related an occasion when one member of the nursing team directly challenged a patient's delusions, and the challenge led to discussions and the first cracks on the overall delusional system and a step towards recovery. The pre-existing relationship with the patient was a very important foundation for this intervention. In fact a longstanding nurse-patient relationship in which the same delusional system had been recounted many times sometimes enabled nurses to be dismissive of delusional talk with not great impact: 'she phones me quite often from the ward when she's unwell, and says, oh I'm off to Monte Carlo with my millionaire husband, and I can now say to her, yeah whatever; I've heard it all before'. With yet other patients, delusions could be soft and malleable, enabling nurses to argue and present evidence that was quickly reassuring for the patient, by checking under beds, in rooms and cupboards etc., for the threats the patients believed were there, or demonstrating that the things with which patients were preoccupied were not actually occurring. Reassurance in such cases tended to only work on a short term basis, 'because it comes back very quickly', but was helpful to the patients concerned.

Don't collude (17/28)

Agreeing with the patient about the veracity of their delusions, perhaps in order to avoid difficult or tense conversations, or for fear of what might happen if they challenge the delusion, or to get the patient to go along with a particular course of action. This was not seen as acceptable behaviour. Many nurses indicated that this was primarily a matter of being honest with the patient. While not wanting to dismiss or deny their

delusions, nurses could not allow themselves to confirm them either. So if a patient put them in a position where they had to express a judgment, the nurse would say things like 'I understand that these are the thoughts you are having' but that the belief was not shared. In this way nurses could maintain themselves as a 'reference point' for patients.

Ignore the delusions (6/28)

With fixed and longstanding delusions, some nurses indicated that it was better to ignore them and give up on any attempts to change them: putting them on the back burner and not putting an emphasis on them sometimes can be really useful as well'. Instead they suggested 'looking again at what might be meaningful activities in his day, and what he might like to do, and being positive about other activities', 'making the most of bits that aren't affected by the delusion'.

Find workarounds (9/10)



When the delusions are of an intensity of nature that they interfere with patients' daily lives, particularly basic functions like eating, drinking and washing, then ways to work around the delusion have to be found. Several nurses spoke about dealing with patients who thought the food and/or drink was being tampered with or poisoned, and suggested allowing the patient to select his own food, tasting it first for them, or providing it as supplied in sealed containers that the patient can undo themselves.

Thought disorder

Overall, thought disorder was not clearly understood by all the interviewees, and advice on how to deal with it and respond to it as a topic rather scant. Several interviewees considered that thought broadcasting and thought insertion (with related delusional ideas) were thought disorders.

A number of different suggestions were mentioned by only one interviewee as opposed to several, including: distracting the patient; reminding them they have got through this experience before; not challenging the thought content; explaining the physiological cause; and helping family and friends to understand.

Acceptance and listening (15/28)

Nurses answers did not so much focus on thought disorder as a topic of conversation or a therapeutic target; instead they circled around what it was like to try to engage in normal conversation with a patient who was severely thought disordered. In this regard it was noted that 'the conversation can veer very quickly to all kinds of places' and 'cover some very whacky themes', nevertheless to stay with the conversation meant 'you could have a social connection with a person when perhaps that's quite rare for them'. To accomplish this required nurses to give plenty of time for the patient to express themselves, be 'calm', 'non threatening', 'not putting too much pressure' and 'not bombard them with questions'.

"I follow people's tangents that they go on, I'll just go with them on the ride essentially. And often I think people on the surface are not making much sense, but ... even if you range over many topics you often will, it will fall around particular themes which then gives you an insight into who that person is, and what's most important for them as well. And also how that style of thinking is affecting them as well, and what's preoccupying them and how that might get in

the way of them doing what they want and what they value in the world, and how they might live what they value."

Explore how it affects them (4/28)

Some interviewees tentatively suggested trying to explore with the thought disordered patient the effect it was having on them, and on their relations with others.

Upset/distress

Acceptance and listening (25/28)

Nurses' responses on this topic emphasised giving time in a quiet, private environment, 'allowing them to be upset' and 'just being with them', eventually moving to asking 'if they want to talk about it' or suggesting that it might 'help to talk about it'. Gentle prompts and questions then allowed nurses to draw out from patients their thoughts, feelings and the events which were distressing them. Taking a distressed person to a private place could also usefully prevent other patients from also getting distressed in sympathy. Time had to be spent with someone in being with them and hearing them, before it was possible to move on to talk about coping, otherwise 'the person can feel invalidated' and that 'you are trying to push their feelings away, sweep it under the carpet'. The interviewees were also careful to state that patients' wish to speak should be respected, and that they shouldn't be put under pressure to expose the causes of their upset, or as put by one nurse: 'not prying'. Being with some 'in silence' and 'not saying anything' can be perfectly acceptable ways to respond, instead 'waiting until they are ready to talk'. If a person is upset and angry, too many questions might 'increase their distress'.

Give time alone (3/28)

If it was what the patient wanted, and an offer of comfort and listening came too soon or was rejected, a distressed patient could be given some time alone, 'but not indefinitely'.

Stay calm and neutral (4/28)

Hearing upset was difficult, but in order to patients to be able to share the depths of their feelings, nurses had to be able to tolerate the distress without becoming 'uncomfortable' themselves. If the nurse themselves can't contain their response to the patient's distress, then the patient will feel less able to be distressed, and communication is hindered. If the nurse responds with overly sympathetic distressed feelings, it can unhelpfully amplify the patient's distress as opposed to helping resolve it, or patients can feel they 'have to protect' the nurse 'from their distress'. The correct response was therefore 'remain calm and show you are interested'.

Don't close them up (11/28)

Perhaps because it is hard to tolerate distress, the interviewees noted that acceptance and listening were sometimes avoided. They therefore suggested that responses to the distressed patient should not include fatuous reassurance, such as 'stop crying, don't worry, everything's going to be OK', or 'it's not that bad, you'll get over it'. Nor was it acceptable to dismiss how someone was feeling, make light of it or try to coerce a better mood through shouting at them or 'telling them to pull themselves together'.

"And I think you've got to be careful, as the practitioner, you're not shutting them up because you're finding it difficult to be around."

Persist to find out cause (7/28)

While patients should not be put under pressure to reveal all, nurses did recommend gentle persistence in order to find out what underpinned patients' distress. Overcoming reticence could be done by repeated contact and offers ('putting in opening gambits every now and again'), spending time in silence with the upset person ('understanding that it might take quite a long time to get to the bottom of it'), finding the right place on the ward, or just homing in on the right moment when the patient was ready to talk.

Explore solutions (9/28)

These can either be offered as possibilities by the nurse, or the patient can be asked what support would help them: 'how can we make this better for you?' A helpful move could be to ask if they have felt this way before, and what has happened previously, what has helped and what hasn't. Alternatively, to elicit their own ideas, the patient could be asked 'what would you tell a friend in your situation?'

Take action to relieve cause (6/28)

If it is something causing the distress that the nursing team can remedy in some way, then appropriate action can be taken. No specific examples were given.

Distraction (6/28)

Involving the patient in various activities was recommended as a way of distracting them from their distress: walks, meals, self-care activities, socialising with fellow patients were all things mentioned by interviewees.

Assess suicide risk (2/28)

Two nurses suggested that distress might indicate raised risk of suicide, and that risk needed to be re-evaluated and assessed when patients were upset.

High arousal

Many interviewees gave mixed responses under both agitation/overactivity and aggression irritability. It was therefore difficult to treat these two areas separately, and they have been merged and considered together under this single heading.

Hear the patient, listen (26/28)

Nurses indicated that it was a mistake to prejudge the aroused patient, or to think of them as being bad, or badly behaved. Instead the correct approach was based on the assumption that 'something has made them feel that way, and it's trying to discover what that something is'. So, when the person concerned may be 'pacing', 'snappy', 'hostile', 'cross', 'looking at you in an intimidating way', 'shouting and hitting the walls', 'threatening verbally', or 'screaming', the first question is 'can you tell me what's going on?' This gave an opportunity for patients to ventilate and communicate their feelings, which was sometimes all that they required to recover their equanimity: 'sometimes people just need to go blah and get it all out of their system ... it gives them a chance to just spew out a bit of info and feel a little less isolated with that, they may be carrying



the world's survival on their shoulders according to what their beliefs are, so that's incredibly daunting'. Many different causes for high arousal were mentioned, including 'fear', 'anxiety', 'being bullied', mood disorder, auditory hallucinations, ideas of reference, real failures on the part of psychiatric services and workers, conflict between patients, 'somebody's said something, looked at somebody in the wrong way, has taken away something that they've been expecting such as having a cigarette or going out for a walk or having their leave, seeing the doctor, not seeing the doctor, not being discussed where they said they were going to be discussed, family not coming up to the ward', or 'distressed, frightened or disturbed about what's going on around them'. There were some cautions and provisos in relation to this recommendation to listen and find the reasons behind the high arousal level. One nurse suggested that with some patients, exploring the cause of their arousal could lead to an increase, even a sudden increase in their anger: 'you can turn the heat up really quickly, without meaning to'. Sometimes the patient is unwilling to co-operate with this process of exploration, with one nurse recounting how a physically strong and fit martial artist paced up and down the ward muttering curses and imprecations, and rejected any attempt to speak with him by walking away, resulting in 'total failure'.

Exercise, physical activity (4/28)

A few nurses indicated that physical exercise, either by allowing the patient to 'stomp around outside' or by gym based activities and exercise, would use up 'their excessive energy'.

"I've had a client before who when he's felt the mania coming on, he's gone running, because he was a runner anyway, so he'd go and jog for three or four miles, and come back and feel a lot calmer about things."

Distract, calming activity (9/28)

If a patient is becoming irritable or agitated, it can sometimes avert escalation, or even resolve the situation, if they are distracted by engagement in other activities. Nurses suggested 'watching a movie', 'playing pool or table tennis', 'a jigsaw puzzle', 'listening to music', 'looking at the paper', 'walking or pacing', cup of tea or coffee, converse about other non stressful topics such as their 'family or job' or recent nice events on the ward.

Request lowered arousal (6/28)

When a patient is becoming more irritated and agitated within the course of an interaction with staff, they might not be fully aware that they are raising their voice and starting to shout. It is possible at this point to

'just ask them to, I am here, I am listening and I want to help you to think but actually I can't really understand what you're saying when you're shouting, you might want to sit with me or you might want to talk to me more quietly and then maybe I can think about what you're saying'.

Relaxation (7/28)

Simple relaxation techniques could be offered and taught to patients, including slow, deep breathing:

"I've seen nurses do relaxation techniques that I would never have thought that someone that agitated would be able to manage and they have managed it so

yeah, as I say I was quite surprised, I didn't think at that level of arousal that relaxation would work but it did'.

Don't argue or confront (14/28)

Becoming aggressive, raising one's voice with all the accompanying body language, was widely reported to be counter productive. This was referred to in different ways, including being 'threatening', 'inflexible', 'confrontational', 'over challenging', 'laying down the law', 'too hard', or 'pushy'.

Relationship leverage (7/28)

A pre-existing good, trusting relationship with the aroused patient can help any crisis calm down much more quickly. Nurses recounted specifically referring to and using their previous relationship with the patient who is aroused, reminding them who they are and how long they have been working together:

'you can refer to your relationship you have with them, you can say we, I know this is something that keeps cropping up and really rubs you the wrong way, I remember we spoke about that ... people are less likely to try and take a swipe at you for a start'.

Give choices, empower (14/28)

Once the initial complaint or issue had been thoroughly explored and defined, the interviewees spoke of the necessity to involve patients in decision-making and finding an acceptable resolution. Such resolutions could result in issues being raised with the patient's consultant psychiatrist or other practical changes. Involving patients and giving them options gave them 'routes out of the situation', and meant they were not placed in 'a psychological corner' from which they might come out fighting. Finding compromises and solutions through negotiation meant that nurses had to be 'flexible' rather than rigid about ward rules, what could and could not be done. Where the high arousal was a consequence of psychiatric symptoms, it was not so easy to find ways to solve them, other than enhancing the patients own coping strategies or other interventions as explored in previous sections, whilst waiting for treatment to take effect.

"If you give them a choice at all time, they may remain very agitated but at least then it can be channelled hopefully in the most, safest way."

Explain what the rules are and the reasoning behind them (15/28)

To the aroused, irritable patient, any constraints on their behaviour can elicit angry outbursts. Nurses gave examples such as asking the patient to go to bed at a reasonable hour, eat, wash, wear sufficient clothing, not expose themselves, not come into the ward office, not shout be abusive or racist, not threaten or bully others, not leave the ward, not damage the furniture and fittings, etc. Demands from patients could also be unrealistic given the workload of the ward or other constraints. The nurses stressed that it was most important to explain to patients why these boundaries existed, and to explore with patients ways that their needs and desires could be met without the rules being broken: 'it's just giving them reasonable boundaries but most importantly saying why you're giving them the boundaries'. Several nurses mentioned that instructions could be given quite forcefully, without the nurse themselves leaking any anger, frustration or irritation: 'firm but not threatening', 'assertive but not aggressive'. It was possible to be forceful 'without shouting at someone who is already irritable and aggressive, and telling them what they've got to do, it can provoke patients'.

"Honesty and empathy and if that means that you're trying to get somebody to avoid doing something that they want to do then you have to explain that that's what it is you're trying to achieve for them."

Describe consequences (5/28)

Nurses also stated that it was sometimes necessary to explain to patients what would happen if they continued to behave aggressively or became physically violent. These nurses suggested that patients could feel 'out of control' and needed the staff to show competence, confidence, and the ability to contain their behaviour. They spoke of explaining 'consequences', 'repercussions' and being a 'little bit inflammatory, a little bit threatening'. References in the text made clear that these consequences included severe containment methods (restraint, coerced medication, seclusion).

Forceful containment (16/28)

In acute situations, where necessary to preserve the safety of patients and those around them, nurses spoke about manually restraining the highly aroused patient, given sedating medication (by injection if necessary), or placing the patient in seclusion. However three nurses' recounted incidents where they had seen patients restrained too quickly, before any discussion had taken place with them about why they were angry, and objected to this, considering it to be poor practice.

Debrief later (7/28)

When there has been a violent incident, then at a later point, perhaps the next day, this needs to be explored and discussed with the patient concerned, 'you need to try and let me understand what's going on, how can we stop that from happening again'. This process involved asking the patient what had happened, to give reasons for behaving the way they did, and exploring with them what the consequences were for others and themselves, all with a view to increase the patient's empathy, understanding, anger management skills and social skills in conflict expression. Perhaps also identifying trigger points where interventions could be made by the staff and patient together at an earlier stage, should the situation be repeated. This was also an opportunity for the staff to explain to the patient why they did what they did (for example, seclude the patient for an hour), in an attempt to prevent the patient from 'holding any grudges'. If there has been a conflict between two patients, then a similar process can be undertaken: 'I'll always get them to sit down and talk to each other'.

Advance directives (8/28)



Outside of a crisis situation, when the patient is relatively well, not agitated, overactive, irritable or aggressive, then is the time to negotiate what to do and how to handle the situation should it recur. The patient can then choose what he or she feels is the best strategy that is most likely to succeed. One nurse gave a detailed account about how such an advance directive could be negotiated, with the nurse utilising the patients history and case record, reminding the patient what had happened before, and tempering their suggestions into a realistic applicable plan about what should happen in the scenarios most likely to recur: 'how do you want us to work with you in that situation ... how would you want us to approach you ... what happens if you say no?' If such negotiation and planning has already been done and the patient is highly aroused now, then the advance directive should be implemented. The presence of such a planned strategy makes the situation much more predictable for the patient as well, and there 'not quite so scary for them', and because of that, less likely to end in a struggle of some kind.

LESSONS FOR PRACTICE

Summary of findings

Analysis and reanalysis of the interviews found that the interaction techniques reported divided into seven natural domains: the moral foundations for interacting; preparation; being with the patient; nonverbal aspects; emotional regulation; getting things done; and talking about symptoms.

The moral foundations incorporated a complex mix of sometimes countervailing imperatives, such as notice and do not ignore the patient, nevertheless avoid intruding and respect their privacy. Also included were values emphasising warmth, care coupled with a high degree of respect and an absence of harshness even under the most challenging circumstances. Honesty was seen as important, particularly in relation to restrictions on patients' liberty and the quality of the service they received.

Interactions were shown to commence prior to meeting the patient, as careful preparation was deemed to increase the chance of success. Such preparations included wide consultation of records and other people who knew the patient concerned, careful observation, consideration of the best time and location to initiate interaction and choosing the right nurse to make the approach.

Simply being with acutely psychotic patients was shown to be a complex activity that could require a considerable number of different adjustments, approaches or interactive techniques. The basic spine of these included simply sitting with the patient or spending time with them, whilst offering light normal conversation, supplemented by the nurse introducing him or herself, focusing on the patient as a person rather than on their symptoms, using props, the local environment or what was happening on the ward as topics, and engaging in a joint activity, spiced with appropriate humour. Where the patient was apathetic and withdrawn, interviewees talked about developing a comfortable silence, or engaging in a one-sided conversation. If the patient was hallucinating, this had to be tolerated and made allowance for in the conversation, and simpler topics chosen; if thought disordered themes could be named, reminders and prompts to the topic given, clarifications sought, things kept simple or the patient could be asked to communicate through writing. For the agitated or overactive patient reducing stimulation, setting interaction limits and giving positive feedback were considered to be helpful. When patients were upset or distressed, normal conversation was generally felt to be inappropriate, similarly in some cases it was judged best to avoid patients who were currently irritable or aggressive. However in the latter case choosing a topic in which the patient was an expert was judged a wise move, whilst at the same time getting them sat down and maintaining clarity.

There was a perhaps surprising quantity of new recommendations about nonverbal communication, vocabulary and the timing of interactions. A slow pace, slow speech, short sentences, simple vocabulary and repetition within and across interactions were recommended. Tone of voice should be both caring and quiet, interactions being short and frequent, with persistence shown in efforts to communicate. There were times and occasions when touch and greater use of gesticulation were judged appropriate, and times when they were not. Writing and drawing were acknowledged as useful alternative communication media. Particular care was recommended with aggressive and irritable patients, with a non-threatening nonverbal stance being required and a cautious choice of the language used.

Whilst communicating, or in order to do so effectively, nurses had to regulate their own emotional responses to what patients were doing and saying. They deemed it most

important not to display any anxiety in the face of acute psychotic symptoms, patients' psychological distress or their overt hostility and aggression. Being calm and receptive in the face of such patient behaviours was deemed more likely to reduce them – becoming anxious more likely to amplify them. Similar recommendations were given about becoming frustrated or irritable with patients uncooperativeness, lack of progress or resistance to actions which would benefit them. Finally an optimistic outlook was considered valuable and motivating for patients (as well as fellow nurses).

Attempting to get things done with patients (e.g. get them to get up or go to bed, eat, drink, wash, take their medication etc.) required a whole range of additional and different interaction techniques, including making suggestions rather than ordering patients to do things, giving reasons for the task, being flexible, maximising choice, prompting, encouraging, giving positive feedback, rendering assistance, and in some circumstances being assertive and forceful. When resistance was based upon delusions, a degree of collusion was allowed by some nurses if balanced by the patient's needs for care. For thought disorder, using gestures as a means of communicating what was to be done was considered helpful.

Talking about symptoms with patients was the single largest domain in the interviews. Absolutely fundamental to all symptom areas was the need for nurses to hear what patients' experiences were, accept them, and seek to enter and understand their effect on patients with caring and respect. This was clearly a foundation for nursing practice, and was the starting point for all other interactions about symptoms. Following this, for apathetic or withdrawn patients, it was judged helpful to mutually explore causes, agree a care plan, develop a routine and purpose, and then take a step by step approach. For hallucinating patients, stress management, distraction, bolstering coping and in some cases casting doubt or challenging the hallucinatory content were considered good approaches. Gentle questioning or direct challenge were also sometimes deemed appropriate for the deluded patient. Collusion was not recommended, however sometimes it was considered appropriate to ignore the delusions or find workarounds so that patients' needs could be met. In the case of upset and distressed patients, interviewees talked about staying calm, keeping patients talking, persisting to find out the cause, and taking action to relieve the cause or exploring other solutions with the patient. Responses on agitation, overactivity, irritability and aggression were not clearly distinguishable and were therefore considered together. The expert nurses recommended exercise, distraction, relaxation, avoidance of confrontation, explaining the reasons for actions and rules, negotiating advance directives and forceful containment.

Novel findings?

This study set out to uncover any tacit or traditional knowledge amongst practicing nurses about how to communicate well with those in a state of acute psychosis. The first assessment of the results must therefore be on what or whether anything new has been discovered. How much of the material above simply repeats the content of nurse training, reflecting the zeitgeist of psychiatric nursing practice, and how much hidden expertise has been uncovered? How much is the above information novel, and how much is an elaboration of the recent knowledge history covered in the introduction?

The pattern of responses and themes in the interviews does indicate that the contents are not widely known. While some techniques were present in two thirds of the interviews, many others were only present in one third or less. And those interviewed were nurses considered to be particularly expert at dealing with patients suffering from acute psychosis. This does not prove the contents are new or undocumented material. It does prove that there is likely to be a considerable number of the techniques described above which are not known by most psychiatric nurses (and therefore not utilised). The low numbers of expert nurses reporting some techniques also

indicated that further interviews might yet find additional material of value. Those low numbers additionally indicated that our findings might be of significant use to nurse educators in the future.

We specifically asked our interviewees not to tell us about 'textbook communication skills', as these were felt to be already widely known by nurses and a significant part of nurse training. These were still mentioned in passing by most nurses, supporting our assumption that they are well known and have been well assimilated into practice. However our research interest was to move beyond these basic skills and describe expert practice specifically with acutely psychotic patients. This presents particular challenges which are not covered in basic communication skills training, namely how to cope with and respond to patients who are apathetic or withdrawn, hallucinating, deluded, agitated or overactive, thought disordered and irritable or aggressive.

Our introduction demonstrated that nurse-patient interaction was both highly valued and considered to occur insufficiently frequently. The recommended practice structures (models, nursing process, primary nursing) and policy (audits and good practice guides) for psychiatric nursing all seek to make improvements to interaction frequency, style and content. Yet as we have also seen, these efforts to improve psychiatric nursing practice do not deliver information on how they are to be implemented with the most seriously and acutely ill patients that nurses cope with on a daily basis.

The value base and approach common to all psychotherapies and summarised so well by Carl Rogers was found in our introduction to be present in diverse sources of expertise in dealing with acutely ill psychiatric patients. It was central to mainstream therapeutic approaches such as psychosocial interventions and cognitive behavioural therapy, through to the work of Laing, Berke and Mosher, generally considered to be fringe or even anti-psychiatric movements. It was also present in new innovations in dementia nursing care and the therapeutic community movement. These values were also clearly reflected by our interviewees and formed the foundation or basis for their approach to acutely psychotic patients. The interviews clearly demonstrated the primacy of listening to patients, linked to respect and care/concern. Rogers' terms seem to have disappeared, but the value and attitude base remains similar. These probably represent universal moral elements of care for the mentally ill and psychologically disturbed.

However our findings also move beyond these basic values in several ways. They articulate the reality that nurses do not always wait for patients to willingly engage in interaction concerning their symptoms and problems. Inpatient psychiatric nursing is a practice that mixes both active and passive stances, and while nurses will sometimes wait for patients to approach them they will also notice patients and seek them out in order to engage with them. The warmth, empathy, interest and acceptance articulated by Rogers are present in the interviews, but they are located within a context that shows that their deployment is a special challenge with acutely ill patients who are unpredictable, angry and sometimes rejecting or aggressive. Rogers' idea of congruence, genuineness or honesty was present in the interviews, but perhaps with a more factual capacity in relation to the realities of inpatient care where nurses represented a whole service provision structure (the hospital) and legal framework of coercive detention. Thus what they had to be honest about was, yes, their feelings of care for and warmth towards patients, but also the reality of the whole panoply of the service which was provided (from hotel services through to the multidisciplinary psychiatric team) and the reality of the patient's legal status (sometimes vehemently rejected by them). Finally, the interviews add another element not in any of the voluntary, therapy based models that presuppose the patient wants to participate. That is that active and passive approaches to acutely psychotic patients have to be judiciously mixed so as to recognise the intensely personal and private nature of psychotic experience.

Related to the active element were a huge range of other interactional issues based on the fact that nurses had to deliver nursing care to people who are in a very psychologically disabled condition. Information on how best to accomplish these was virtually absent from any part of the literature, yet forms a very considerable part of the findings of this study.

Barriers to nurse-patient communication

A wide variety of recommendations were made by our interviewees about interaction with patients, but it is legitimate to ask how compatible these are with the realities of daily life on the wards. Only half of nursing staff in face to face contact with patients receive any systematic training whatsoever (Bowers, Jones, & Simpson 2007). On many shifts there may be only one or two qualified nurses on duty (48% of all daytime shifts, unpublished data from 136 wards), accompanied by a mix of health care assistants and student nurses. The qualified nurses have to answer all phone calls to the ward, manage the visits of other disciplines, supervise the junior staff in their activities, respond to patient requests, queries and crises, and spend a significant amount of time giving out medications. Taking into account the time required for writing up nursing notes, taking handover from the previous shift and giving it to the next, this leaves precious little time for anything else, even on a well staffed shift.

Thus having uninterrupted time to sit down with a patient and respectfully listen to their experience, is at a premium. Such times are more likely to occur on night duty when demands are reduced because many patients are asleep, or at weekends because of reduced demands to service other professionals visiting the ward. Opportunities at other times are a scarce resource. The reality of interactions between patients and staff is that they tend to be brief, and conducted on the fly in the midst of other activities. This can be an asset in certain circumstances, and our interviewees did point out that joint activities were ways to develop conversation with patients, and that some patients mental state did require interactions to be short and to the point. However interactions are conducted by those with minimal or incomplete training far more frequently than with a qualified nurse – a situation that causes considerable frustration to those who have assiduously trained for three years to practice as a skilled and qualified psychiatric nurse. This is not to say that no time is ever available, nor that there are some wards and teams where the time that is available is wasted in doing nothing or staff making social conversations with each other. An efficiently managed and hardworking staff team can make the best of those opportunities which are available. And the fact that our expert nurses could talk about a wide range of techniques and skills demonstrated that they had acquired these in practice and they were feasible.

The environment of the ward can also provide obstacles. If quiet privacy was the best location for meaningful conversation, then appropriate rooms had to be available. Yet many wards in outdated buildings would find such provision a challenge. And even if such rooms were available, for a nurse to go with a patient into such a room removed one person from general supervision of the ward and patients – an important task to be able to provide instant support to patients with fluctuating and unpredictable mental states, to prevent aggression, bullying, self-harm and absconding. Trying to converse within the ward day room or public areas meant that passers by could overhear what was being said, making both parties self-conscious and guarded. Meanwhile the nurse was open to being approached and interrupted by other patients with requests and demands.

Another way of regarding these competing pressures is to consider the nurses' tasks. Their first priority was to keep patients safe, and this meant keeping them on the ward when necessary, and keeping a constant supervisory eye over every patient and every area of the ward. That observation enabled them to complete the second task of assessment – monitoring the condition and behaviour of patients to inform other members of the team, enabling correct treatment and diagnosis. The third task, that of

giving treatment, centres currently mainly around giving medication, involving four lengthy medication rounds each day, including persuading reluctant patients to take their medication, checking that they have been taken, answering questions and assessing for side effects, plus a lot of communications with doctors and pharmacy about medication changes, discharge medications, leave medications, etc. Lastly comes making sure that patients eat and drink sufficient for their health, have clean clothes to wear, take baths, shave, cut their nails, etc. Interaction takes place alongside these tasks, but not a great deal of time is left over for general conversation to build relationships. Structured therapeutic interactions are possibly amongst the last in a long line of priorities.

It also needs to be recognised that the psychotic experience itself represents a very real barrier to effective communication. It is an alien, abnormal and private experience, thus accessing it from outside and understanding it are problematic. Cognitive processing is compromised: the patient's concentration, memory and ability to understand are adversely affected, thus acquiring or giving information is difficult. Inpatients are frequently hostile, mistrustful and angry because of their confinement on the ward, the restrictions placed on them, close living with other people, mood changes, delusions and hallucinations; all of which pose challenges to nurses' efforts to establish and maintain a supportive relationship. Strange, bizarre and frankly funny beliefs, talk and actions by patients mean that maintaining overt respect requires effort and delicate balancing. Lack of interest, inertia, apathy on the part of patients mean that undaunted and excess energy is required from the staff, not just once, but over and over again. Moreover, our interviews of staff grossly oversimplified the interactional challenge by considering symptoms groups separately. In the real world patients experience combinations of symptoms (e.g. thought disorder, delusions, apathy and irritability) and their experience changes over time, even during the course of a single nursing shift. Getting interaction just right for the patient, the moment and the task therefore takes great skill and artistry, and the challenge should not be underestimated.

Psychotherapy and the acutely ill psychotic patient

Our interviews failed to uncover any new psychotherapeutic methods. All that were mentioned were applications of already known methods, mainly client-centred therapy, solution focused therapy, and cognitive behavioural therapy. Client-centred therapy was only applied in terms of its value base, and was not formally embarked upon as a matter of systematically producing reductions in psychotic symptomatology. With the other two types, psychotherapy with acutely ill patients tended towards simplistic and basic applications of the most fundamental techniques. The impression given from the interviews was that these were delivered in an *ad hoc* and sporadic manner by individual clinicians, rather than being an overall framework within which the whole nursing team worked. This observation remains valid even though interviewees occasionally mentioned wards where, for example, hearing voices groups were held regularly. Strikingly absent was any mention of psychoanalysis or the associated idea of defence mechanisms, although these might provide a rich resource for understanding and construing patient behaviours.

The nursing focus to a far greater extent was focused upon being with patients in a supportive way as a moral necessity and duty to those in psychological distress. Beyond that, the priorities were keeping patients safe, assessing their mental state, delivering medical treatment and physical care. Communication was a vehicle to accomplish these important goals, through establishing relationships and finding ways to negotiate and manage the hurdles posed by psychotic symptoms. Psychotherapeutic strategies to directly counteract or reduce symptom were a much smaller part of the overall picture of daily nursing care.

There is little in the way of evidence for the efficacy of any psychotherapy for inpatients with acute psychosis. The only studies which have been conducted are those utilising cognitive behavioural approaches, and although these have reported good results, they are insufficient in number and size for a high level of confidence in their findings. Trials with inpatients present enormous difficulties. When patients are very ill, they often do not have the capacity to give informed consent. Cooperation with therapy can be poor, and inpatient stays are relatively short. Even the implementation of psychotherapeutic ideas into the general practice of inpatient psychiatric nursing can be difficult (McCann & Bowers 2005). Nevertheless this is an important area for further development and research as, if effective applications can be found and proven, they might pay big dividends in reducing patients' length of stay in hospital and separation from their normal everyday lives.

Some implications

What would be the outcome if all nurse-patient interaction was informed by and applied the techniques reported by this study? They would certainly seem to enhance the possibility of cooperation and collaboration between nurses and patients. If so the delivery of medication, accuracy of assessments, and physical health status of patients might all be improved. It also seems logical to conclude that aggression and violence might be reduced, either through the easier accomplishment of necessary tasks with patients, or through more effective and rapid de-escalation with irritable, agitated and aggressive patients. As the risk of suicide amongst inpatients is as much of a problem with psychotic patients as it is with those who are depressed (Bowers, Banda, & Nijman 2009) it is a possibility that better communication would reduce social isolation and hence risk. Finally it might be supposed that patients who are in receipt of such a highly skilled approach might have a greater satisfaction with the care they receive and potentially be more willing to be admitted to hospital on subsequent occasions, without the use of legal detention. Whether this broad range of benefits can actually be delivered remains a matter for further research.

The contents of this book are derived from interviews with expert practicing nurses about interaction with acutely ill patients within service delivery settings. However the authors have increasingly come to recognise that what is described here could be widely useful to other professionals who have to deal with acutely mentally ill people (police, ambulance personnel, social workers, general practitioners and psychiatrists), and to family and friends of the mentally ill, many of whom have few sources of concrete advice on how to deal with the situations they face in their daily contact with people who suffer psychotic disorders.

Increasing the skill set of nurses who deliver care to patients in inpatient wards will require some changes to nursing education. Pre-registration nursing education will need to move beyond the basic communication skill set which is currently taught. While the content of this still remains very valid and applicable, this research has described additional techniques and strategies which it would be valuable for every nurse to have readily available in their 'toolbox' of social skills. However, in order to spend time with disturbed patients, such nurses also need to have a thoroughgoing knowledge of psychopathology and psychiatric symptoms, coupled with the best possible understanding of what it feels like to be psychotic. During training, much of which takes place in practice, it would be highly valuable for students to seek out patients who were able to describe this experience for them. This could usefully be supplemented by wide reading of patient accounts, patient poetry, art, etc. Health care assistants also have a great deal of contact time, but no training in communication skills at all. It could be most valuable to services and the patients they care for if some of the expert practices described here could be taught to this group of workers.

Finally, we reflect as authors that in our experience, consistently applying these techniques requires the thickest of skins covering the deepest of hearts fed by the largest of passions.

APPENDIX – THE INTERVIEW SCHEDULE

In this interview we are particularly interested in hearing about the ways experienced staff communicate with patients during their spells of acute psychosis. We want to hear about the verbal and non verbal techniques you use (or those you have witnessed others using). We'd like to hear about the ones you think work and those that don't (or those that sometimes do!).

We don't particularly want to hear about the textbook communication skills things like paying attention to people, giving feedback, reflecting, etc. – unless you have a particular angle or different use (or view) of such things.

1. Can you tell me a bit about your experience of looking after acutely psychotic patients? What sort of things do you like or not like about it?

The following questions I am about to ask fall into seven domains. First I'm going to ask about patients who are apathetic or withdrawn, then I'm going to ask in turn about patients who are hallucinating, deluded, thought disordered, upset or distressed, agitated or overactive, and finally aggressive or irritable.

Is that OK, are you clear about that?

First domain. Patients who are APATHETIC and/or WITHDRAWN

1.1 If you want to just spend some time with a patient who is very apathetic and/or withdrawn, how do you go about doing that?

1.2 How do you try to build a relationship with a patient who is very apathetic and/or withdrawn?

1.3 Do any of these things (or anything other kind of communication or conversation with them) reduce the degree of apathy/withdrawal?

1.4 What about when you need to accomplish some kind of task with a patient in this condition, say get them up in the morning, get them to have a bath, or eat something, or take their medication?

1.5 Are there any other strategies you use or have tried with apathetic and/or withdrawn patients?

1.6 Is there anything else you've seen others try, successfully or unsuccessfully?

1.7 Is there anything that shouldn't be tried with people who are apathetic and/or withdrawn?

1.8 Is there anything else you can tell us about working successfully with patients who are like this?

I'd like to ask you now about patients with positive symptoms – firstly about those who are hearing voices or who have other sorts of hallucinations.

Second domain. Patients who are HALLUCINATING

2.1 If you want to just spend some time with a patient who is hallucinating, how do you go about doing that?

2.2 How do you build a relationship with hallucinating patients?

2.3 Is there a way of talking with them that might reduce their hallucinations during the conversation?

2.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

2.5 Are there any other strategies you use or have tried with actively hallucinating patients?

2.6 Is there anything you've seen others try, successfully or unsuccessfully?

2.7 Is there anything that shouldn't be tried with people who are hallucinating?

2.8 Is there anything else you can tell us about working successfully with patients who are in this state?

I'm now going to ask you a similar set of questions about very deluded patients.

Third domain. Patients who are DELUDED

3.1 If you want to just spend some time with a patient who is deluded, how do you go about doing that?

3.2 How do you try to build a relationship with those patients?

3.3 Is there a way of talking with them that might reduce the extent of their delusions or their preoccupation with them?

3.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

3.5 Are there any other strategies you use or have tried with very deluded patients?

3.6 Is there anything you've seen others try, successfully or unsuccessfully?

3.7 Is there anything that shouldn't be tried with people who are deluded?

3.8 Is there anything else you can tell us about working successfully with patients who are in this state?

We are about half way through the interview now.

Fourth domain. Patients who are THOUGHT DISORDERED

4.1 If you want to just spend some time with a patient who is thought disordered, how do you go about doing that?

4.2 How do you try to build a relationship with those patients?

4.3 Is there a way of talking with them that might reduce the severity of their thought disorder?

4.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

4.5 Are there any other strategies you use or have tried with very thought disordered patients?

4.6 Is there anything you've seen others try, successfully or unsuccessfully?

4.7 Is there anything that shouldn't be tried with people who are thought disordered?

4.8 Is there anything else you can tell us about working successfully with patients who are in this state?

Can we talk now about agitated and/or overactive patients?

Fifth domain. Patients who are AGITATED and/or OVERACTIVE

5.1 If you want to just spend some time with a patient who is agitated and/or overactive, how do you go about doing that?

5.2 How do you try to build a relationship with those patients?

5.3 Is there any way of talking with them that reduces their agitation or overactivity?

5.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

5.5 Are there any other strategies you use or have tried with agitated and/or overactive patients?

5.6 Is there anything you've seen others try, successfully or unsuccessfully?

5.7 Is there anything that shouldn't be tried with people who are agitated and/or overactive?

5.8 Is there anything else you can tell us about working successfully with patients who are in this state?

Sixth domain. Patients who are UPSET and/or DISTRESSED

6.1 If you want to just spend some time with a patient who is upset and/or distressed, how do you go about doing that?

6.2 How do you try to build a relationship with those patients?

6.3 Is there any way of talking with them that reduces their upset or distress?

6.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

6.5 Are there any other strategies you use or have tried with upset and/or distressed patients?

6.6 Is there anything you've seen others try, successfully or unsuccessfully?

6.7 Is there anything that shouldn't be tried with people who are upset and/or distressed?

6.8 Is there anything else you can tell us about working successfully with patients who are in this state?

Seventh domain. Patients who are IRRITABLE and/or AGGRESSIVE

7.1 If you want to just spend some time with a patient who is irritable and/or aggressive, how do you go about doing that?

7.2 How do you try to build a relationship with those patients?

7.3 Is there any way of talking with them that reduces their irritability?

7.4 How about accomplishing some kind of task with such a person, say getting them to wash, or go to bed, or eat a meal. How do you go about doing that?

7.5 Are there any other strategies you use or have tried with irritable and/or aggressive patients?

7.6 Is there anything you've seen others try, successfully or unsuccessfully?

7.7 Is there anything that shouldn't be tried with people who are aggressive and/or irritable?

7.8 Is there anything else you can tell us about working successfully with patients who are in this state?

One final, last question.

8. Is there anything else you can tell us about communicating with and interacting with acutely psychotic patients?

Many thanks for your time in completing this interview. That's been really helpful

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