

Caught between compassion and control: Exploring the challenges associated with inpatient adolescent mental health care in an independent hospital.

ABSTRACT

Aim. To extend our understanding of how healthcare assistants construct and manage demanding situations in a secure mental health setting and to explore the effects on their health and wellbeing, in order to provide recommendations for enhanced support.

Background. Contemporary literature acknowledges high rates of occupational stress and burnout among healthcare assistants, suggesting the context in which they work places them at elevated risk of physical harm and psychological distress. Yet, there is a deficit of qualitative research exploring the experiences of healthcare assistants in adolescent inpatient facilities.

Design. An exploratory multi-method qualitative approach was used to collect data about the challenges faced by healthcare assistants working on secure adolescent mental health wards in an independent hospital during 2014.

Method. Fifteen sets of data were collected. Ten participants completed diary entries and five participants were also interviewed allowing for triangulation. Data were analysed using Interpretive Phenomenological Analysis.

Findings. The findings illustrated how inpatient mental health care is a unique and distinctive area of nursing, where disturbing behaviour is often normalised and detached from the outside world. Healthcare assistants often experienced tension between their personal moral code which orientate them towards empathy and support, and the emotional detachment and control expected by the organisation, contributing to burnout and moral distress.

Conclusions. This study yielded insights into mental health nursing and specifically the phenomenon of moral distress. Given the ever-increasing demand for healthcare professionals, the effects of moral distress on both the lives of healthcare assistants and patient care, merits further study.

SUMMARY STATEMENT

Why is this research or review needed?

- There is limited research exploring healthcare assistants, yet the utilisation of high levels of healthcare assistants is reflective of mental health inpatient care within the UK and is increasing.
- There have been significant changes in the organisation of mental health services in the UK, with an increase in the number of beds provided by the independent sector.
- The utilisation of qualitative methodology offers an in-depth exploration of healthcare assistants and reduces a significant gap in knowledge of inpatient mental healthcare in independent hospitals.

What are the key findings?

- The findings illustrated that inpatient mental healthcare continues to be a unique and distinctive area of psychiatry, where disturbing behaviour is often normalised and separated from the outside world. The article further extends our understanding of the emerging field of moral distress in clinical contexts.
- Healthcare assistants experienced a persuasive tension between their personal moral code, and the emotional detachment and control expected by the organisation, often contributing to moral distress and burnout.
- Healthcare assistants perceived a significant absence in organisational support. Nevertheless, with a significant increase in accessible and consistent peer and psychological support, healthcare assistants may alleviate moral distress and regain their autonomy.

How should the findings be used to influence policy/practice/research/education?

- Through recognising numerous clinical issues which cause significant distress to healthcare assistants, organisations may wish to develop the mechanisms by which they aim to support healthcare assistants' emotional and psychological needs.
- Given the current demand for healthcare professionals, and the continually increasing needs of healthcare provision, this findings of the study should contribute to optimising retention in mental healthcare.
- Due to the effect of moral distress on healthcare assistants and patient care, this phenomenon needs to be addressed more fully in terms of both research and intervention.

INTRODUCTION

Mental healthcare is often described as a complex, demanding and unique occupation (Zarea et al. 2013). The stressful nature of the profession, acts of violence, threats of suicide, self-harm and unpredictable behaviours, poor pay and unattractive shift patterns contribute to the ongoing difficulty in recruiting and retaining mental healthcare professionals in the United Kingdom (Nolan & Smojkis 2003). Moreover, the association of mental healthcare and stress and burnout is well documented in contemporary literature (Happell 2009), and is known to substantially increase the likelihood of physical and mental disorders (Nolan & Smojkis, 2003). Mental disorders comprise of a broad range of problems with different symptoms, however are often characterized by abnormal cognitions, emotions, moods and behaviours (WHO, 2014a). Consequently, mental health professionals are considered likely to be more susceptible to anxiety, depression and post-traumatic stress disorder (Happell 2008). However, in the UK there is limited research exploring adolescent inpatient healthcare assistants working in the context of mental health and further understanding is needed in order to inform appropriate care and support interventions for staff. Whilst services are organised differently in different countries similar patterns of low retention and satisfaction rates amongst healthcare staff in mental health settings have been reported internationally (Ito et al 2001; Ward 2011) suggesting that new research findings may be transferable to several countries.

BACKGROUND

Inpatient facilities provide care for the most distressed and mentally ill individuals in society, whose mental health problems cannot be treated safely in the community (Stenhouse 2011). In the UK and other Western countries adolescent inpatient care is becoming increasingly specialised as adolescents form a heterogeneous patient group with mixed disorders and multiple diagnoses (Ellilä et al. 2007). However, often consumers of inpatient services display acute symptoms such as suicidal intentions, hallucinations, delusions and a risk of harm to themselves and others (Ngako et al. 2012), generally resulting from experiences of trauma, emotional mistreatment, sexual abuse, neglect, loss, family discord, addiction, criminality and severe mental disorders (Van Sant & Patterson 2013). Consequently, adolescent mental health nursing staff represent a specialised cohort of healthcare professionals informing both the setting and population of this study.

In England inpatient care is the largest component of mental health services, subsequently inpatient facilities are the largest employer of healthcare professionals (Greatley 2004), despite recent investments in community services (Chow & Priebe 2013). However, the demand for inpatient beds significantly outweighs the number of beds available in England (Baker et al. 2014). Therefore, patients typically enter inpatient facilities at a later stage of their illness and often present with more clinically severe symptoms and increasingly disturbed behaviours (Geller & Biebel 2006). As a result, inpatient facilities are frequently pressured, under-staffed and under-resourced environments (Brennan et al. 2006). Consequently, in the UK since the late 20th century, violence and aggression has substantially increased (Bilgin & Buzlu 2006), and presents serious hazards for the safety and well-being of healthcare professionals (Jacobowitz 2013).

Inpatient mental healthcare is considered a highly stressful occupation both for qualified mental health nurses and healthcare assistants (Jenkins & Elliot 2004, Davis et al. 2013). Occupational stress

is a response displayed when work related demands and pressures are inconsistent with knowledge and/or abilities, therefore challenging the individual's ability to cope (WHO 2014b). In accordance with Siegrist's (1996) effort reward imbalance model, high levels of work related effort, a requirement of mental healthcare employees, should be matched by high levels of reward. However, nursing pay is relatively poor, particularly for healthcare assistants, therefore occupational stress and negative health outcomes are likely (Mark & Smith 2012). Occupational stress may cause changes in physiological, psychological and behavioural functioning, detrimental to both health and wellbeing and potentially patient care (Richter & Whittington 2006). Occupational stress may also contribute to reduced productivity, burnout, absenteeism, litigation, recruitment and retention issues, with subsequent costs for NHS trusts and independent organisations (Cottrell 2001, Gates 2001). It is well documented that significant exposure to occupational stress is associated with burnout (Pompili et al. 2006, Happell 2008). Burnout is a syndrome which occurs in staff working in caring professions, resulting in emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach & Goldberg 1998). It is characterised by a decrease in energy, self-esteem and productivity, and hopelessness, cynicism, self-depletion and dehumanising individual patients (Taylor & Barling 2004). Burnout also adversely affects patient care (Lee & Akhtar 2011), as healthcare professionals physically and/or psychologically withdraw from patient interactions (Peterson et al. 2008).

Many individuals working in health and care professions can also experience a degree of discord between institutional policies and practices and individual principles (Jameton 1984). The term moral distress refers to the psychological, emotional and physiological suffering that healthcare professionals experience when they act in ways that are inconsistent with deeply held ethical values, beliefs or commitments (McCarthy & Gastmans 2015). One literature review clustered the sources of moral distress into the following groups: clinical situations (episodes of treatment perceived to be aggressive or futile, and incompetent or inadequate care), difficult working conditions and limited resources (under-staffing, cost cuts and economic efficiencies), structural conditions and moral sources (perceived lack of decisional authority and support), and personal failings (a sense of lack of moral competency, knowledge, courage and/or self-doubt) (McCarthy & Gastmans 2015). Moral distress is thought to contribute to desensitization, as healthcare professionals become passive and silent towards moral challenges, and ultimately moral distress may lead to burnout, staff retention issues, and poor patient care (McCarthy & Gastmans 2015). Nevertheless, experiencing episodes of moral distress may also facilitate learning and personal and professional growth through the development of greater self-awareness and resilience, stronger moral resolve and clearer ethical commitments (Hanna 2004), as healthcare professionals may regret their previous actions and change their behaviour in future situations (Hamric 2012).

In the UK there is limited research exploring adolescent inpatient healthcare assistants working in the context of mental health. As a result of a recent shift within the nursing profession formally qualified/registered mental health nurses have a higher standard of education than previous generations, and with complex treatments and packages of care, the role of the qualified nurse has changed beyond recognition (Department of Health 2010). Consequently, direct care previously undertaken by qualified mental health nurses is often delegated to other, lower paid unqualified nurses, namely healthcare assistants (Gournay 2005). Thus they are often the first individuals to encounter challenging situations on the ward. The utilisation of high levels of healthcare assistants is reflective of the staff profile of the independent hospital in this study, and of inpatient care within

the United Kingdom more generally (Department of Health 2010). Moreover, there have been significant changes in the organisation of mental health services in the UK, with a substantial increase in the number of mental health beds provided by the independent sector (Jaycock & Bamber 2001). However, to date only one study published in the United Kingdom, explored registered nurses' experiences of working with adolescents in secure inpatient facilities, outside of the National Health Service (Dickens et al. 2005). Therefore, the utilisation of qualitative methodology offers an in-depth exploration of the phenomena specifically with healthcare assistants and reduces a significant gap in existing knowledge of adolescent mental healthcare in independent hospitals.

THE STUDY

Aim

The primary aim is to extend our understanding of how healthcare assistants construct and manage demanding situations in a secure mental health setting in the independent sector. The secondary aim is to explore the effect of this environment on healthcare assistants' health and wellbeing, in order to provide recommendations for enhancing effective coping and support.

Design

The study used the principles and processes of Interpretive Phenomenological Analysis (Smith et al. 2009). This approach to qualitative research stresses the importance of collecting rich sets of experiential data which are viewed through a lens of critical realism (Finlay, 2009) and of valuing each individual case before drawing connections across the sample. It also emphasizes a process of 'double hermeneutics' where the final analysis represents a co-construction of how the participant has made sense of his/her experiences and how the researcher has interpreted the account that the participant provides (Smith & Osborn 2003). Its in-depth nature requires very close attention to working with the data and it is therefore well suited to rich experiential data collected from a small number of individuals sharing a similar significant experience. These individuals are viewed as 'experiential experts' in the phenomenon being scrutinised (Smith et al. 2009).

Sampling and selection procedure

Ten participants were recruited from two secure female adolescent wards in an English independent mental health hospital. Ten participants were considered a suitable participant number due to the idiographic nature of Interpretive Phenomenological Analysis (Smith et al. 2009). Inclusion criteria consisted of healthcare assistants, in permanent or casual positions, who worked regularly and with a minimum of six months experience. Seven female and three male participants were included in the study aged between 21 and 43. Seven participants held undergraduate or postgraduate degrees. Two participants were permanent employees, and the remaining casual bureau employees.

Data collection

Data were collected through diaries and follow-up semi-structured interviews. Both methods fit well with the aims of interpretative phenomenology. Diaries allow accounts to be captured as or very soon after events occur whilst subsequent interviews facilitate both a process of reflection and sense-making on the part of the participant and also provide focus for the interviewer to probe

further interesting and salient material recorded in the diaries (Williamson et al. 2015). Fifteen sets of data were collected during 2014. The ten participants were provided with guidelines for completing their diaries and were asked to maintain a diary for a minimum of six shifts. Participants were given a number of open-ended prompts focusing on the experiences and challenges associated with inpatient adolescent mental health nursing. Five of the participants participated in follow-up semi-structured interviews lasting approximately 60 minutes. During the interview, the researchers referred to material from participants' diaries to elaborate and clarify areas of interest and also asked some open-ended questions about their views and experiences of work.

Ethical considerations

This study was approved by a university ethics committee and an independent mental health hospitals ethics committee. All names used are pseudonyms to protect participants' identity. Participants gave signed consent for both elements of the study and were provided with a window post-participation to withdraw or modify their contribution if they wished. Details of support agencies were provided upon debriefing.

Data analysis

Interviews were transcribed in full using an abbreviated form of the Jefferson system of notation (Jefferson 2004). All data were analysed using the conventions of interpretative phenomenological analysis (Smith et al 2009). Thus, data analysis evolved over four stages: (1) reading and re-reading the data, (2) identifying and labelling emergent themes, (3) developing theme tables, and (4) developing thematic maps.

Rigour

Meyrick's (2006) review of rigour in qualitative research centres on transparency and systematic negotiation throughout the research process and these principles and processes informed all elements of the study being reported. More specifically these were addressed by detailing the study's aims and focus of analysis, using appropriate methods of data collection and analysis; providing details about sampling; providing details about data collection; using two data collection methods (diaries and semi-structured interviews) to add to the confirmability of interpretations; providing clear association between results and conclusions; and providing links to other relevant literature to assist in the identification of implications for practice.

FINDINGS

Three inter-related themes have been selected for discussion in this paper – all are illustrated with a series of extracts from diary and interview data. The themes identified and discussed in the following section are: normalising an abnormal environment, between compassion and control, and imbalance of occupational demands and support. It is of note that other themes identified in the data covered material around the emotionally rewarding nature of the mental health profession, emotions regarding physical patient restraint, the increasing burden of paperwork and bureaucracy, and stigmatisation of staff with mental health issues.

Normalising an abnormal environment

Participants' reported experiences of operating in a way which is detached from everyday living, (and indeed other hospital environments) expressing the unique nature of adolescent mental healthcare and the inpatient environment. For example Liv describes an incident where a patient uses a broken cup aggressively; within an inpatient environment this everyday object takes on a different meaning and can be used to inflict harm.

"She was threatening us with the larger pieces of the ceramic cup (.) so we couldn't go near her (.) she had a weapon (.) and she was still slashing at her arms (.) (Liv, Interview).

Goffman's (1961) research on post-war asylums considered life in an asylum to be utterly removed from normal everyday living, similar to Liv's modern day conceptualisation. However, the removal from normal living may be somewhat inevitable as inpatient facilities support the most distressed and acutely ill members of society (Stubbs & Dickens 2008).

"I have seen and been involved in many Nasogastric intubation feeds and I separate myself from what is happening and the distress that the patient shows. I think of it as a job that has to be done for the good of the patient. I think if I was to watch it on a screen I would definitely feel different about it and more than likely feel upset by the process " (Liv, Diary).

Within this environment Liv maintains a detached and pragmatic professional identity and is able to detach herself from the distress of a patient with anorexia nervosa on whom she is performing a Nasogastric intubation feed. Liv acknowledges that if she were an independent observer to this procedure she would perceive this as disturbing and potentially unacceptable behaviour (Owens 2004). However, within the inpatient environment this is a normalised everyday occurrence and part of her duties and thus she strongly justifies her participation. Moreover, Sam describes how disturbing behaviour is normalised within the confines of the inpatient facility.

"You do become desensitised because I think you have to in order to deal with it, it just becomes an everyday thing. I witness self-harm and suicidal behaviour every single day and I've seen a patient hanging from the ceiling. It's just part of the job." (Sam, Diary).

Desensitisation is the process of diminished emotional responsiveness to a negative stimulus as a result of repeated exposure (Hardcastle et al. 2007). It is well documented that healthcare professionals who provide care for adolescents who regularly self-harm often become desensitised and even frustrated by this behaviour (Allen & Jones 2002). Sam believes desensitisation allows him to disassociate and cope with the unique nature and demands of the occupation. Sam equates desensitisation with resilience and professionalism, a somewhat counterintuitive conceptualisation to the holistic patient centred discourse of modern day healthcare (Brown et al. 2014, Pelto-Piri et al. 2014). However, Marcus described the emotional burden of working with adolescents who engage in self-harm.

"Self-harm is one aspect I find very difficult despite my long experience in this environment it never gets easier seeing and feeling a young person's distress and suffering." (Marcus, Diary).

Marcus displays an overriding sense of compassion and is unable to normalise severe and destructive behaviour. Empirical evidence indicates approximately one-half of mental healthcare professionals experience psychological strain similar to that described here (Eriksen et al. 2006). In accordance to the Job Strain Model high psychological demands and low occupational control result

in psychological strain (Karasek 1979). When a patient engages in self-harm the demand on Marcus' psychological wellbeing is high and his control low. Psychological strain is associated with a number of adverse outcomes including fatigue, anxiety and an elevated risk of physical and mental disorders (Karasek & Theorell 1990), highlighting the need for both peer and professional support (Hyrkas 2005).

Between compassion and control

Within the inpatient facility participants operate in an environment removed from everyday living, as a consequence participants demonstrated tension between their personal moral code and the emotional detachment and control expected by the organisation in which they work. This pervasive tension is well documented within psychiatry (Goffman 1961, Keski-Valkama et al. 2010).

"The medicalisation approach of care for psychiatric patients has overlooked the principles of "care" in the context of nursing, and consequently the emphasis seems to have shifted more towards safety management and personal risk." (David, Diary).

David describes a medical approach in mental healthcare which focuses on the physical and physiological aspects of a patient's condition rather than assessing all dimensions of the person (physical, emotional, mental and spiritual) to provide holistic care. Mental healthcare aspires to provide patient-centred and compassionate care, yet often promotes detached and depersonalised care (Pelto-Piri et al. 2014). This tension may contribute to a loss of personal autonomy of staff, which is constructed and maintained by the unique and complex environment. This tension may be particularly pertinent for healthcare assistants and other low paid healthcare professionals situated near the bottom of the hospital hierarchy.

"Institutional constraints are one of my primary stressors, I find that institutional constraints do not promote person centred values, but rather are punitive to a group of vulnerable, damaged young people that are in need of inspiration, hope and innovation guided care. The lack of such things makes me extremely frustrated and resentful to the organisation." (Marcus, Diary).

Marcus is alienated by a profession that promotes discourse around individualised and empathetic care, from working in an organisation which appears to promote depersonalised and detached care. The discourse of the profession and the organisation in which he works are largely counterintuitive, resulting in a range of negative emotions. Whilst, Marcus believes he should comply with institutional norms and formal decision making he is also strongly aware of his own belief system and moral values, resulting in a battle to maintain personal autonomy, and consequently moral distress.

"The challenges I faced were ethical, having a duty of care I find it hard to actively let a patient self-harm in such a harmful manner but at the same time I felt I had no choice but to follow the senior member of staff's lead." (Edward, Diary).

Edward described feeling inferior and constrained by a senior's decision and appears to experience moral distress. As indicated previously "moral distress" describes the stress experienced when one is constrained from acting in accordance with one's own set of moral values as a result of external constraints (Corley et al. 2005). Helene also describes a sense of powerlessness to provide compassionate care in this account of an interaction with a patient.

"I went in she was crying her eyes out so I went to sit and de-escalate and talk to her and they told me to come out (.) they were like right we've seen she's alive (.) and I was SHOCKED I didn't even know what to say (.) I'm being told by my nurse in charge we've seen she's alive come out (.) I could have spent two minutes talking to her (.) calming her down and then she would have gone to sleep (.) whereas instead she continued crying and I was upset" (Helene, Interview).

Moral distress is thought to comprise of emotional, psychological and physiological responses including feelings of anger, frustration and guilt (McCarthy & Gastmans 2015). Feelings which left unresolved may have negative and enduring consequences on both healthcare professionals (McCarthy & Deady 2008), and patient outcomes (Bell & Breslin 2008).

"Human nature is to react but on a professional level can we? (.) and what's appropriate and reasonable?... so I get really anxious unless I'm 100% certain that's the right stage or if I haven't dealt with it before you can panic that perhaps you aren't doing the right thing and then if you leave them are you not caring for them so I can get quite nervous about it (.) obviously you've got the risk to them and then you've got to live with it (.) I think it can be really daunting" (Lucy, Interview).

Lucy goes beyond a simple acknowledgment of moral distress and describes the difficulties of decision making in a high risk environment. Lucy attempts to disengage her conscious and primal instincts in order to engage a professional persona. However, she struggles to disengage entirely and adopt the depersonalised approach of the organisation, as she fears the consequences to both the patient and herself, highlighting Lucy's concerns around striking an appropriate balance between professionalism and compassion. Interestingly, these are concepts which are often juxtaposed within contemporary nursing discourse (Pelto-Piri et al. 2014).

"Although, no self-harm occurred which I was very happy about, I did have some feelings of ambivalence about the outcome. Although it was positive, I was aware that unlike my usual motivations for supporting a young person which includes being caring, compassionate and empathetic for the young person suffering, I offered the support to avoid increasing my stress levels and ultimately I felt that was a selfish action. This has made me feel very upset with myself, because I am always so happy with my intentions which have always been based on altruism and a genuine desire to alleviate young people's suffering." (Marcus, Diary)

Marcus acknowledges his motivation as individualistic and battles with his compromising sense of morality and ethics, as he attempts to maintain his identity and self-esteem. Whilst Marcus's personal motivations are altruistic and patient centred the environment alters his perception and subsequent behaviour, Marcus is effectively becoming institutionalised. This is reflective of Goffman's (1961) research in which he describes a loss of identity and the assumption of a purely institutional role. Tension between personal and professional identities is also known to contribute to burnout (Happell 2009). Consequently, Marcus is emotionally exhausted and therefore struggles to interact with patients for motivations beyond individualistic gain, which results in Marcus experiencing feelings of guilt and reduced personal accomplishment.

Emotionally it can affect you a lot there's been times where I have been close to tears with something's I've seen (.) with me being a big grown man (.) it takes its toll because you see something (.) it's like a horror movie" (Sam, Interview)

Sam describes feeling emotionally burdened after observing self-harm, Sam elicits an identity struggle utilising his masculinity to highlight the emotionally demanding nature of mental healthcare when even “a big grown man” can come close to tears through his observations of self-harm, highlighting the influence on Sam’s emotional wellbeing, and in turn arguably increasing the likelihood of burnout.

Imbalance between occupational demands and support

Participants perceived that the organisation in which they work systematically failed to nurture their wellbeing and has no real sense of their psychological needs. Therefore, participants employ personalised and individualistic coping mechanisms to continue operating in an abnormal environment and to ameliorate the identity struggle between their personal and professional belief systems and moral values.

“The stress of feeling like I had to do everything on my own, and looking after 9 different patients, with no support, and ultimately the panic of finding someone with a ligature was pretty stressful! I was mostly angry for being left in that situation and felt so unsupported. You really rely on members of the team and when you feel like you can’t, that leaves you feeling pissed off at best and vulnerable and unsafe at worst!” (Sophia, Diary)

“Although there is support from immediate staff, I don’t think the support extends to higher up the chain. I think we had one or two staff support sessions over four years and that was all we got” (Gemma, Diary).

Sophia describes feeling unsupported in a dangerous situation. Sophia and Gemma are heavily reliant on the other staff on the ward in similar job roles to themselves, and when this support system fails it leads to a poor and unsafe working environment and diminished patient care (McCarthy & Gastmans 2015). Moreover, both Sophia and Gemma feel subordinated to those above them.

“When I first started, I was taking a lot of the stress home with me and found it hard with nobody to talk to but, over the time I’ve been there, I have opened up a lot more to the ward staff and found it a lot easier to cope with. I try not to dwell on things or let things get me down. I try not to take negative things to work or think about the previous day. (Gemma, Diary).

Gemma describes the coping mechanisms she has developed independently of formal support in her hospital. These include developing a positive and optimistic attitude, effective communication and a strong social support system. Similarly, optimism and social support are well-documented coping mechanisms in contemporary mental healthcare research (Cleary et al. 2012). Interestingly, within the inpatient environment Gemma elicits an overtly optimistic persona which acts as a buffer against the stressors of the environment and provides a protective barrier to her wellbeing. Humour is also reported to be effective coping mechanism in mental healthcare (Bennett & Lengacher 2008, McCreddie & Wiggins, 2008).

“I think the only way to cope with the stress of the job is to have a laugh with your colleagues and hopefully the patients when they are in good moods. If you didn’t laugh I think you would either cry or go mental yourself.” (Helene, Diary)

“I have found that you tend to develop a darker side of humour. Laughing something off will help me to cope with it a lot easier and not to dwell. If you don’t laugh you’ll cry.” (Liv, Diary)

Helene indirectly refers to the patients she cares for using pejorative term “mental” which may suggest she views the patients in this way, however this may be a result of the detached care promoted by the organisation rather than a genuine loss of compassion. Helene and Liv describe laughter as an essential coping mechanism in light of the demanding and emotional nature of mental healthcare. Freud (1920) originally described laughter as a coping mechanism utilised when one is upset, angry or sad, suggesting laughter distracts ones conscious brain from the negative stimulus to prevent one from becoming tearful. Helene and Liv also describe humour as a coping mechanism and both utilised the phrase “if you don’t laugh you’ll cry”, a reflection of Freud’s (1920) research, suggesting humour may be utilised as both a coping and a defence mechanism to mask distress and burden. A growing body of literature is exploring how health care professionals use laughter (especially ‘black humour’) to alleviate stress in challenging hospital environments, especially where patient recovery rates are low (Harris 2014).

DISCUSSION

It is evident that adolescent mental healthcare is a unique, distinct and demanding area of psychiatry requiring resilience, compassion and commitment. Normalising an abnormal environment explored the way in which healthcare assistants operated within the inpatient environment, suggesting inpatient care was spatially, socially and psychologically removed from everyday living. Despite radical changes to the organisation and philosophy behind mental health services these findings continue to reflect Goffman’s (1961) research which described psychiatric inpatient care as operating as a closed social system, sealed from the outside world. Participants were aware of the distinct nature of their profession operating outside of the perceptual field of nursing and as a consequence sought to clarify and justify their individual practise (Pelto-Piri et al. 2014). Some participants described becoming desensitised to disturbing behaviours whilst others described anxieties particularly regarding self-harm, often resulting in emotional distress. Nevertheless, with accessible and consistent peer and expert psychological support such distress may be substantially reduced (Hyrkas 2005).

Between compassion and control encapsulated the consequences of operating in an environment removed from everyday living and captured tensions between participants’ personal moral codes, which drive compassion and support, and the emotional detachment and control expected from the organisation in which they work. Contemporary literature acknowledges compassion as a desirable quality within mental healthcare, although a series of recent reports have highlighted considerable and systemic lapses in compassionate care (Ballatt & Campling 2011). The phenomenon of moral distress is central to this study, and given the current demand for healthcare professionals, the effect moral distress takes on the personal and professional lives of healthcare assistants, the quality of patient care and the continually increasing needs of healthcare provision, it would seem moral distress is a phenomenon that needs to be addressed more fully in terms of both research and intervention (McCarthy & Gastmans 2015). Whilst we have focused on a very particular context it appears that many elements of moral distress transcend a range of clinical environments especially where working conditions are challenging and patient recovery rates are low (Kwisoon et al. 2015). However, discourse surrounding moral distress is not without controversy, and the definition itself is

sometimes considered conceptually flawed, suffering from both theoretical and measurement difficulties (Johnstone & Hutchinson 2015).

Furthermore, literature acknowledges significant levels of burnout in healthcare assistants (Jenkins & Elliott 2004), however an organisational structure that empowers healthcare assistants through access to resources, support, and opportunities (O'Brien 2011), has been shown to significantly reduce burnout (Kash et al. 2000). Disconcertingly, in the current study all participants reported experiencing elements of burnout at some point in their current role. Imbalance of occupational demands and support described the way in which participants coped in an organisation which they perceive systematically failed to nurture their wellbeing. Participants developed personalised and individualistic coping mechanisms and relied substantially on social support from immediate colleagues. Existing literature indicates consistent positive effects of social support and wellbeing in mental healthcare (Kilfedder et al. 2001, Davey et al. 2014). Furthermore, high levels of social support are associated with lower levels of stress (Hamaideh 2011), burnout (Coffey & Coleman 2001), and increased job satisfaction (Sundin et al. 2007), through encompassing the human needs for security, social contact, approval, belonging and affection (House 1981).

Consistent peer and professional support is considered to significantly reduce burnout and moral distress (Fox 2011). Access to appropriate psychological support at the hospital where the research took place was described as inadequate by a number of the participants. However, this may also be reflective of participants' employment status as low paid, mostly casual employees, suggesting healthcare assistants are not wholly valued by the hospital. The utilisation of diaries allowed healthcare assistants to describe their experience in their own words, provided a breadth of important clinical issues and fostered individual reflection. It also allowed an opportunity for participants to capture thoughts and emotions very soon after incidents occurred on the ward. Participant's diaries varied in content, length and structure, although collectively participants provided rich in-depth data. Some participants described the diary as an invaluable aid to coping in an organisation that provides little opportunity for support.

Contemporary healthcare literature also identified diary-keeping as a therapeutic tool (Travers 2010, Smith-Battle et al. 2013). Therefore, healthcare providers may consider utilising diaries as an effective method to identify clinical issues and effectively support mental health nurses. The utilisation of diaries was also complemented with a number of follow-up semi-structured interviews. Interviews allowed for reflection and provided participants with an opportunity to explain the meaning of their experiences, providing a richer level of understanding and data. The utilisation of two methodologies allowed for data triangulation, an extended understanding of the phenomenon and a more in-depth, multidimensional insight to the complexity of the social world (Moran-Ellis et al. 2006).

CONCLUSION

In summary, the findings illustrated that inpatient mental healthcare continues to be a unique and distinctive area of psychiatry, where disturbing behaviour is often normalised and separated from the outside world. Healthcare assistants often experienced a persuasive tension between their personal moral code, which drives nurses towards empathy and support, and the emotional detachment and control expected by the organisation, in which they work, contributing to numerous emotional implications, most notably moral distress and burnout. Furthermore, healthcare

assistants perceived a significant absence in organisational support. Nevertheless, with a significant increase in accessible and consistent peer and psychological support, healthcare assistants may alleviate moral distress and regain their autonomy.

This study yielded valuable insights into the phenomena of adolescent mental healthcare and highlighted the utilisation of diaries as a valuable therapeutic tool within healthcare research. However, a limitation of this study is the sample utilised permanent and casual employees who worked regularly on a ward for a minimum of six months, although burnout and moral distress were prominent themes, permanent staff and nurses who worked in this environment for a considerable period of time may experience substantially higher levels of burnout and moral distress. Furthermore, the majority of participants were degree-educated and many were undertaking the healthcare assistant role as experience for accessing better paid and higher status careers. Moreover, seven participants were in their twenties and may not have developed the skills to manage moral distress adequately. Therefore, further research is required with larger and more diverse samples. Nevertheless, through recognising numerous clinical issues which cause significant distress to healthcare assistants, organisations may change the way in which they support their emotional and psychological needs, optimising recruitment and retention in mental healthcare (Robinson et al. 2005). Future research should identify why healthcare assistants choose to stay in mental healthcare to assist in retaining an already stretched workforce.

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