



MONASH University

**Women Living with Psychosis and Being Cared for in Kingdom of Saudi
Arabia: A Phenomenological Study**

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BSN, MSN

A thesis submitted for the degree of Doctor of Philosophy at Monash University

Monash Nursing and Midwifery

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Abstract

The consumer experience of psychosis, including recovery, has received attention in terms of western mental health research. There has been some acknowledgement in literature about the experiences of mental health nurses during their care provision for consumers living with psychosis. However, there is a significant gap in evidence that addresses the experiences of women diagnosed with psychosis, and nurses' experiences of caring for women with psychosis within the Kingdom of Saudi Arabia (KSA). The aims of this study were to explore the experiences of women living with psychosis in KSA. Additionally, it explores nurses' experiences of caring for women with psychosis in KSA.

The study utilised van Manen's hermeneutic phenomenological methodology, taking individual interviews as the main method of data collection to support thematic analysis of the data. Women with psychosis (n=21) and nurses (n=21) were recruited from two mental health facilities in Riyadh in KSA. The nurses revealed multiple challenges associated with their care provision related to issues of the limited provision of therapeutic healing mental health spaces in KSA, their own limited understandings of psychosis and related emotional difficulties, and their struggles with developing relationships and communications with others, with reference to language differences. The women with psychosis described their personal experiences of the phenomenon of psychosis and the related challenges of first onset; admission or follow up in mental health facilities, including their difficulties communicating their needs to nurses; community support or rejection after discharge.

The women and nurses together offered many insights into the challenges they face, which were significant in terms of their implications both in the KSA context and internationally. As this research is contextually specific to the KSA, however, the findings will help the KSA mental health workforce with the rethinking of mental health nursing education. Both groups

revealed a need to prepare additional and more extensive healing spaces, as well as to establish mental health education programmes for both consumers and the wider community to increase awareness of psychosis. Internationally, benefit may be gained from further examination of the insights into cultural aspects of mental health nursing in KSA developed in this work. Participants highlighted the need to address language differences to develop mutual understanding and therapeutic connection in such contexts.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Print Name: Norah Alyahya

Thesis Including Published Works General Declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes two original papers published in peer reviewed journals. The core themes of the thesis are the lived experiences of women with psychosis and nurses providing care for women with psychosis in KSA. The ideas, development and writing up of all the papers in the thesis were, principally, my responsibility as the candidate working within the Monash Nursing and Midwifery under the supervision of Dr. Ian Munro and Associate Professor Cheryle Moss.

Professor Wendy Cross is acknowledged as a previous supervisor and for her early contributions to the research. She contributed the ideas related to publication of scholarly papers.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into the student-based research.

In the case of Chapters Two and Three, my contribution to the work is stated in the following table. Additionally, specific publication declarations are provided in Chapters Two and Three.

Thesis Chapter	Publication Title	Publication Status	Nature and Extent (%) of Student's Contribution	Co-author names Nature and % of Co-author's contribution	Co-authors Monash Student Y/N
Chapter Two	Advancing Mental Health Nursing Practice in the Kingdom of Saudi Arabia: Rethinking Nursing Care for Consumers with Psychosis	Published	Concept and argument construction, searching, and lead author primarily responsible for writing the paper 70%	1) Ian Munro, academic guidance, constructing the argument, commenting on drafts, assisting development of the paper, and critical review 15% 2) Cheryle Moss, academic guidance, constructing the argument, commenting on drafts, assisting development of the paper, and critical review 15%	No
Chapter Three	The Experience of Psychosis and Recovery from Consumers' Perspectives: An Integrative Literature Review	Published	Concept and argument construction, searching, and lead author primarily responsible for writing the paper 70%	1) Ian Munro, academic guidance, constructing the argument, commenting on drafts, assisting development of the paper, and critical review 15% 2) Cheryle Moss, academic guidance, constructing the argument, commenting on drafts, assisting development of the paper, and critical review 15%	No
Additionally: Professor Wendy Cross is acknowledged for her early contributions to the two papers. This was mainly in the form of providing academic guidance, assisting to construct the arguments, and commenting on some early drafts of the papers.					

I have not renumbered sections of submitted papers to generate a consistent presentation within the thesis.

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The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student and co-authors' contributions to this work.

Main Supervisor name: Ian Munro

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List of Abbreviations

ACMHN	Australian College of Mental Health Nurses
APA	American Psychiatric Association, United States of America
CCTV	Closed-Circuit Television
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPGWG	Early Psychosis Guidelines Writing Group, Australia
GAMHSS	General Administration for Mental Health and Social Services, KSA
GBD	Global Burden of Disease
GP	General Practitioner
GT	Grounded Theory
IRB	Institutional Review Board, Hospital B, KSA
JBİ	Joanna Briggs Institute
JBİ-QARI	Joanna Briggs Institute-Qualitative Assessment and Review Instrument
KSA	Kingdom of Saudi Arabia
MHA	Mental Health Act, KSA
MOH	Ministry of Health, KSA
NMC	Nursing and Midwifery Council, UK
NSW Health	New South Wales, Ministry of Health, Australia
OCD	Obsessive Compulsive Disorder
OPD	Outpatient Department, KSA
PHC	Primary Health Care
PPP	Postpartum Psychosis
RN	Registered Nurse

SACM	Saudi Arabian Council of Ministers
SAH	South Australian Health
SAMHA	Saudi Arabian Mental and Social Health Atlas
SNMHS	Saudi National Mental Health Survey
TV	Television
UK	United Kingdom
WHO	World Health Organization

Chapter One: Introduction to the Research

1.1 Introduction

This thesis reports on the findings of a study undertaken in the Kingdom of Saudi Arabia (KSA) of the experiences of women with psychosis and the nurses who provide care for them, investigated using hermeneutic phenomenology. This chapter introduces the intent and significance of the research, followed by a commentary on the state of the mental healthcare system in KSA. An overview of religious, cultural, and gender-related factors affecting mental healthcare is presented, and the impacts of these factors on women with mental illness in the KSA setting are revealed. Further context to the thesis is also provided regarding the researcher's background, including relevant information about her professional and academic background, motivations, and interest in conducting research on women with psychosis and mental health nursing within KSA. The chapter ends with an outline of the structure of the thesis and a brief explanation of the content of each chapter.

1.2 Research intent

The overall aims of this research are as follows:

- To explore the experiences of women living with psychosis in KSA.
- To explore nurses' experiences of caring for women with psychosis in KSA.

The research objectives were therefore to

- Explore the lived experiences of women with psychosis in KSA.
- Understand the experience of nursing care for women with psychosis.
- Explore nurses' understanding of the management of psychosis in KSA women.

- Explore nurses' interventions and provision of care for women experiencing psychosis in the KSA context.

1.3 Significance of the research

Several studies of individuals' experiences of psychosis already exist and have contributed significantly to this area of mental health. These studies have considered consumer experiences with psychosis from different angles, including those of recovery (de Wet, Swartz, & Chiliza, 2015; Jose, Lalitha, Gandhi, & Desai, 2015; Thomas et al., 2016); physical health during first episode psychosis (Chee, Wynaden, & Heslop, 2019); and social support experiences (Cheng, Tu, & Yang, 2016).

Researchers into mental health nursing have explored the perspectives and experiences of nurses working with consumers experiencing psychosis. Examples of this type of research include investigations of nurses' experiences of offering care to inpatients (Thompson et al., 2019); factors impacting such care (Odeyemi, Morrissey, & Donohue, 2018); nurses' experiences of the use of physical activities as part of their care for consumers (Carlbo, Claesson, & Aström, 2018).

However, a thorough review of the literature reveals significant gaps in knowledge related to these topics in the specific context of KSA. Even in the broader internationally based literature, there is a significant gap in research on women's lived experiences with psychosis. There is a further gap in research on nurses' personal and professional experiences of working with mental health consumers, especially women with psychosis. These knowledge gaps are examined in further detail in Chapters Two, Three, and Four of this study and justify the present work.

This study contributes to the development of an understanding of the experiences of women with psychosis and an investigation of how nurses working in mental health in KSA

experience their provision of care to women with psychosis. A better understanding of these experiences will be gained, enabling service providers and other key stakeholders to identify and address gaps in service delivery as part of the improvement of the overall delivery of mental health services in KSA and possibly more widely. This research should also assist in reducing the gap in current research, based on a consideration of women's experiences of psychosis and how they are cared for, thereby supporting the understanding of women's mental health in KSA.

It is essential to investigate the lived experiences of both women with psychosis and the nurses who provide care to women for several reasons:

- To address the gap in the literature and develop a deeper understanding of women's lived experiences of psychosis and nurses' experiences of providing care to women, particularly considering the specific factors at play in KSA.
- To advance research into women's mental health generally and mental health nursing in KSA more specifically.
- To develop practical recommendations for future education, practice, and policy amendments to improve mental health nursing care.

1.4 The mental healthcare system in KSA

The context for this research is the KSA, and some discussion of KSA's mental health legislation, policies, and services is required for context of the research. The mental healthcare system in KSA is regulated by the Ministry of Health (MOH), which finances and delivers most segments of the KSA health care system, although various semi-governmental agencies and private sector providers also deliver certain aspects of care (Almasabi & Thomas, 2017; Issa, 2021).

Since mental health care is currently seen as an important area by the KSA government (Al Mousa, Callaghan, Michail, & Caswell, 2021), any review of the development of the KSA mental healthcare system requires an examination of existing government policies and regulations, in addition to an overview of national reports and a literature review of existing research on the national mental healthcare system. Research for this thesis commenced in 2016, and the researcher continued searching for contemporary literature in the KSA context during the period of the investigation. However, many primary documents describing the KSA mental healthcare system are outdated, and no further updates were published during the research period. Few documents exist which are reliable sources of information on the KSA mental healthcare system. The following paragraphs identify the key relevant documents and offer a brief description of each.

For KSA governmental documents on mental health, the MOH website provides the most frequently updated information. Examples of such information include the *Statistical yearbook 2020* (2021b) and the *Executive regulations of mental health law* (2021a). The *Mental health care law* (2014), which is not MOH document, is the only document available about mental health law in the appropriate context.

In terms of wider KSA reports about the national mental healthcare system, two sources were revealed by literature searching: two editions of the Saudi Arabian Mental and Social Health Atlas (SAMHA): Al Habeeb and Qureshi (2010) and Al-Habeeb, Helmi, and Qureshi (2016). Al Habeeb and Qureshi (2010) noted the most recent significant step forward in the KSA mental healthcare system was the 2007 SAMHA, which was designed to systematically determine and address issues in the KSA mental healthcare system. The specific goal of this atlas was to describe the current state of mental health and social services in the KSA by collecting, synthesising, and distributing relevant data, as well as to facilitate subsequent institutional evaluations (Al-Habeeb et al., 2016). Al Habeeb and Qureshi (2010) published

SAMHA-2, based on the follow-up plan, with the intent of ensuring that all original targets in the original SAMHA were met. The most recent update of SAMHA was completed in 2015 by Al-Habeeb et al. (2016); this helped to determine which of the gaps earlier identified in the mental healthcare system had been bridged, and which remained to be addressed. This atlas also stressed the ongoing need to further improve mental healthcare systems in terms of various financial and service-based aspects (Al-Habeeb et al., 2016).

Alongside these resources, the most recently updated World Health Organization (WHO) atlas (2019) is the *Mental health atlas 2017: Resources for mental health in the Eastern Mediterranean Region*. This mental health atlas proved to be a useful tool for this research, as it provides a relatively comprehensive assessment of statistical data on the development of the KSA mental healthcare system, compared with those of other *Eastern Mediterranean Region* countries, or indeed those of its global neighbours. However, specific sources of updated details about KSA mental healthcare systems were not provided in this document.

In relation to literature reviews assessing national mental health development in KSA, there have been only two reviews within the time frame considered in the present thesis: Qureshi, Al-Habeeb, and Koenig (2013) and Koenig et al. (2014). These literature reviews examined the central issues of mental health in the KSA, including the mental healthcare system and the epidemiological distributions of some mental health problems.

As a part of the MOH's strategic plan in the KSA vision 2030 (MOH, 2019), the country's mental healthcare system is rapidly improving its capability to meet the mental health needs of citizens (Jimenez & Jacob, 2020). In addition, the MOH has also intensified its efforts to improve the quality of mental health care services in KSA, mainly by drafting health plans and policies (Al Mousa et al., 2021). The elements of the KSA mental healthcare system are included in the policy, legislation, and service focuses, which are highlighted in the following sub-sections.

1.4.1 Policy and legislation

The KSA adopted Islamic Law (Sharia) as its national law, and any health legislation must be consistent in practice with both Sharia law and international standards (Saudi Arabian Council of Ministers [SACM], 2014). In 2014, the SACM passed the mental health care law, which adopted several recommendations promoted by the WHO as part of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991). The KSA Mental Health Act (MHA) (2014) prescribes mental health laws and other legal requirements related to the care offered to consumers by health providers. However, several necessary amendments to this law are still required, as this legislation does not yet meet international standards on assessing and respecting a consumer's capacity to decide on treatment; there is also, as yet, no established independent review body (Carlisle, 2018). However, as the MHA lays out the current overall standards of mental health care, it is linked to several issues investigated in the present research and can be better understood by exploring the nursing care offered to women with psychosis compared with the legal rights of women to receive appropriate treatment and care.

In relation to financing in the KSA mental healthcare system, 4% of the health care budget of the MOH is dedicated to funding mental health care services (WHO, 2019). This rate of spending rises above the global median, which is less than 2%. However, as KSA is a high-income country, this rate is below the median percentage of high-income countries, which is 6% (WHO, 2018b).

1.4.2 Mental health services and institutions

The KSA mental healthcare system supports a wide range of services and institutions. Al-Habeeb et al. (2016) explain that the General Administration for Mental Health and Social Services (GAMHSS) functions under the authority of the MOH and acts to plan, implement,

organise, evaluate, and oversee the delivery of mental health services across the country. The GAMHSS structure and function are intended to align with the fundamental elements of mental health service development proposed by the WHO (2003). In terms of the proportions of consumers using the relevant mental health services, Al-Habeeb et al. (2016) revealed that half of all consumers of both genders are treated in Outpatient Departments (OPDs), 40% in inpatient mental hospitals, while 10% are in alternative facilities, such as community-based residential facilities. In relation to women, 46% are treated in mental health inpatient services in hospitals, and only 4% in other facilities (Al-Habeeb et al., 2016). According to the WHO (2019), the various mental health facilities in KSA treat 953.8 people each year per 100,000 people, a rate of almost 1% of the population, most of whom are treated for non-affective psychosis, bipolar disorder, or depression.

For KSA citizens, mental health care is provided free at the point of delivery (Al-Hanawi, Mwale, & Kamninga, 2020) in government hospitals which offer both inpatient and outpatient mental health facilities (MOH, 2021b). The private mental health service sector in KSA is also growing, and offers treatments that must be paid for either by means of health insurance policies or from consumers' personal funds (Qureshi et al., 2013). In addition, according to the MOH (2018), some independent mental health clinics also exist throughout KSA, and many private general hospitals have connections with these private mental health clinics.

The mental health referral system has three levels of referrals for treatment (Al-Habeeb et al., 2016). The primary level is from General Practitioners (GPs), who act as Primary Health Care (PHC) providers (Al-Habeeb et al., 2016). When GPs reach the limits of their mental health expertise, they must make referrals to a psychiatrist in a general hospital, which is the secondary level (Koenig et al., 2014). If these psychiatrists are unable to adequately address the needs of referred consumers, they must then create referrals to a specialty mental health hospital or teaching hospital, which represents the tertiary level (Koenig et al., 2014).

However, in the KSA it is also possible to be seen directly by a psychiatrist at a hospital, without a referral from a GP, by visiting an emergency centre at any general or mental health hospital, as emergency doctors can also make referrals if necessary (Koenig et al., 2014).

In terms of access to psychotropic medication, most of the population has free access to such treatments from government hospitals (MOH, 2021b). Interestingly, anyone can also purchase psychotropic medications from retail pharmacies without prescriptions, with the exception of benzodiazepines (Alosaimi et al., 2016). Individuals often rely on informal advice regarding psychotropic medication, which is a considerable cause for concern, as this could easily lead to the misuse of these potent drugs. To address this issue, stronger policies have been recommended to prevent retail pharmacies from dispensing psychotropic medications without prescription (Alosaimi et al., 2016). However, to date no study has suggested that there is yet any movement in the development of policy or law restraining pharmacists from dispensing such medications.

The various KSA mental health services are discussed in detail in the following sub-sections. These focus on mental health hospitals, PHC services, relevant human resources, and mental health research.

1.4.2.1 Mental health hospitals

The Taif Mental Hospital was the first to be established in KSA, and opened in the 1950s in Shahr, an hour's drive to the south-east of Mecca, in the western region (Koenig et al., 2014). However, by the early 1980s, there were still only two specialist mental health hospitals serving the entire Kingdom (Koenig et al., 2014), which at that time was home to around 10 million people (United Nations Economic and Social Commission for Western Asia, 2011). In the decades since the 1980s, there has been a ten-fold increase in specialist mental health hospitals in KSA (WHO, 2011), and according to the latest statistics from the

MOH (2021b), there are now 19 specialist mental health hospitals across the country's 13 regions, so that each region has at least one specialist mental health hospital offering fundamental mental health care, including emergency services, with facilities for both in- and out-patient treatment. There are also 337 general government hospitals in the country which offer mental health services (MOH, 2021b). Children and adolescents are served by the government mental health facilities in these general hospitals and the specialist mental health hospitals, children's hospitals, and teaching hospitals (Al-Habeeb et al., 2016). Mothers who develop mental health problems in the immediate postpartum period are treated along with their children in government maternity and children's hospitals, which is achieved through a referral system linked to the specialist mental health hospitals (Al-Habeeb et al., 2016). Private general hospitals also provide mental health services in the Kingdom, and by 2019, the number of these hospitals nationally had reached 158 (Global Health Exhibition and Congress, 2019).

With regard to the number of beds in mental health inpatient wards, the latest update assessed this as being 17.11 per 100,000 people (WHO, 2019). Table 1.1 is adapted from the statistics provided in the *Mental Health Atlas 2017: Resources for mental health in the Eastern Mediterranean Region* (2019), and it compares beds in mental health wards in KSA with those in the Eastern Mediterranean Region, where the KSA is located, and the world.

Table 1.1: Mental health hospital beds per 100,000 people in KSA, the Eastern Mediterranean Region, and globally

Region	Mental hospital beds per 100,000 population
KSA	17.11
Eastern Mediterranean Region	4.07
Global	11.29

Based on this table, KSA has the highest number of beds per 100,000 people in its own region; however, when KSA is compared to other high-income countries such as Austria,

Germany, and France, it falls short of the average of 31.1 beds per 100,000 population seen in this group (WHO, 2018b). Despite the fact that a number of those countries are now moving towards de-institutionalisation and the provision of more extensive community-based care to limit the use of mental health inpatient wards which can separate people from their home communities (Sealy, 2012). While these countries move towards de-institutionalisation, this should cause a decrease in the demand for mental health ward beds, but they still have far higher numbers of beds than KSA (WHO, 2018b), where de-institutionalisation has not yet even been trialled (Al-Habeeb et al., 2016). This indicates that there is a gap in provision in terms of the low number of mental health beds in KSA. Further, while half of all KSA consumers with mental health problems are treated in OPDs (Al-Habeeb et al., 2016), these are not sufficiently effective or robust to support a move to de-institutionalisation and a further corresponding decrease in mental health beds; such moves rely on the foundation of a well-developed community mental healthcare system, which does not currently exist in KSA (Al-Subaie, Al-Habeeb, & Altwaijri, 2020). However, the MOH recently established a national committee to plan for and support community mental health services, which may change the situation in the future (Al-Subaie et al., 2020).

In terms of the duration of inpatient treatment, 85.6% of inpatients typically remain in mental health facilities for less than 12 months, with the remainder divided equally between stays of two to five years and more than five years (WHO, 2019). Globally, the average length of inpatient stay in mental hospitals in developed countries such as the United Kingdom (UK) is lower (Adlington et al., 2018); in Australia, in the period 2016-17, the average length of stay was just 12.7 days (Australian Institute of Health Welfare, 2019). According to Koenig et al. (2014), there are many causes of longer-term stays in KSA compared with the rest of the world: these include the refusal of family members to care for their relatives, the severity of symptoms, the limited number of community support services, the lack of *halfway homes*,

and legal concerns surrounding premature discharge where there are concerns the person may act in an unsafe manner towards themselves or others.

1.4.2.2 Primary Health Care (PHC)

PHC services in mental health are still evolving in the KSA, and by 2020, the total number of primary care centres in the country was 2,257 (MOH, 2021b). PHC is mainly situated in clinics or residential facilities, and is associated with the early detection of mental health problems and referrals to the secondary level based on a severity index and the complexity of the problem (Al-Habeeb et al., 2016). However, the limited availability of mental health services at these PHC centres remains an issue, and the planned well-developed community mental healthcare system is still a work in progress in KSA (Al-Subaie et al., 2020).

With regard to the prescription of medication in PHC centres, Qureshi et al. (2013) affirmed that GPs in the PHC sector are restricted in what they can prescribe: a limited range of medications, such as oral antidepressants. They are not allowed to prescribe antipsychotic or anxiolytic medications, even though, as discussed earlier, people can buy some of these medications at a pharmacy without prescription (Alosaimi et al., 2016; Qureshi et al., 2013), highlighting some contradictions in this area. However, GPs in PHC may, in acute emergencies such as where consumers are agitated or violent, prescribe an intravenous or intramuscular benzodiazepine to facilitate the transfer of such consumers to hospital (Qureshi et al., 2013). These GPs are also allowed to refill repeat prescriptions for consumers with chronic psychosis in cases where mental health hospitals have referred them for follow-up treatment (Qureshi et al., 2013). As a result, mental health training is becoming increasingly recommended and important to primary care physicians (Al-Habeeb et al., 2016).

1.4.2.3 Human resources

This sub-section examines the literature on those individuals involved in mental health care in the KSA, including the various levels of training and qualifications available to them.

1.4.2.3.1 Mental health care staff

KSA mental health professionals occur at a rate of 19.4 per 100,000 head of population; this number includes psychiatrists, other specialist doctors, psychologists, nurses, and social workers in the field (WHO, 2018c). This rate is higher than the global average of 6.6 per 100,000, but much lower than the median rate among high-income countries of 64.3 per 100,000 (WHO, 2018b). More specifically, there are 1.3 psychiatrists, 1.4 other specialist doctors, two psychologists, four social workers, and 10.7 nurses per 100,00 people, giving a proportion of nurses to other mental health professionals of 55%, which almost the same as that seen globally (53%) (WHO, 2018b, 2018c). However, more detailed information, specifically data about the proportion of KSA and non-KSA nurses working in mental health in the country, is not available. The concern in this case is particularly with the proportions of Arabic and non-Arabic speakers, as most nurses in all specialties in KSA are expatriates, and the prevalent language used in KSA hospitals is English (Alenezi, 2017; Suliman & Tadros, 2011). The information gap in this area is concerning, as the number of expatriate nurses in mental health significantly affects the extent to which communication and language difference issues between nurses and consumers may impact consumers' experiences.

1.4.2.3.2 Mental health care training

The latest available review of KSA mental health professional qualifications was conducted by Qureshi et al. (2013), and reported on the number of students graduating in the various mental health disciplines in KSA per 100,000 people. The disciplines of interest were

psychology (0.2/100,000), psychiatry (0.4/100,000), social work (1.0/100,000), nursing (1.8/100,000), and other disciplines (3.8/100,000) (Qureshi et al., 2013).

In terms of nurses' education, the majority of nurses in KSA mental health facilities do not receive any specialist mental health education before they start work; they are reliant on the minimal amount of mental health training included in their undergraduate general nurse training (Al Habeeb & Qureshi, 2010). Therefore, nurses must hold a Bachelor's degree or an Associate Diploma in general nursing and be licensed to practice as a nurse by the competent authority (MOH, 2021a). Koenig et al. (2014) reported that thirteen medical schools in KSA offer postgraduate training in mental health nursing; nevertheless, it is not mandatory for nurses to attend this training before they begin working in mental health.

In terms of in-service education and training, Al-Habeeb et al. (2016) observed that KSA hospitals provide continuous medical education for nurses. However, while some nurses working in mental health hospitals and services attend short courses on certain aspects of mental health, only four percent of these nurses have been educated in the use and effects of psychotropic medications and only 11% have been trained specifically in psychosocial interventions (Al Habeeb & Qureshi, 2010). In contrast, in the UK, in common with various European and other wealthy countries, including Australia, mental health nurses are almost always trained in psychosocial interventions, especially for severe mental illness, in addition receiving medication management training (Gournay, 2005). Education levels in KSA must be considered low in terms of mental health nursing, which represents a serious gap that must be addressed. The latest national report in this area was Al Habeeb and Qureshi (2010), although this argued that, in general, much higher levels of mental health specialist education and continuous educational development are required in KSA.

One aim of this research is to explore nurses' experiences of providing care to women with psychosis in KSA. As the literature about mental health nursing in this context is limited and

outdated, a discursive discussion about advancing mental health nursing practice for consumers with psychosis in KSA is presented in Chapter Two to support this study.

1.4.2.4 Mental health research in KSA

As indicated earlier in this section, there is currently a paucity of research related to mental healthcare systems in KSA, and the little that does exist is outdated. The annual reports of the MOH provide updated statistical yearbooks and a list of executive regulations passed in relation to mental health law (MOH, 2021a; 2021b). While two KSA mental health atlases (Al-Habeeb & Qureshi, 2010; Al-Habeeb et al., 2016) have been published within the last decade, and a further two literature reviews have been published focusing on KSA mental health (Koenig et al., 2014; Qureshi et al., 2013).

National research on mental health problems in the KSA has also been limited. Previous research has relied on two primary sources: the Global Burden of Disease (GBD) Initiative developed by the Institute of Health Metrics at the University of Washington (Memish et al., 2014), and smaller studies based on limited samples of consumers in KSA (Al-Subaie et al., 2020). Some latter studies have focused on developing findings in relation to specific problems and have considered only regional community samples; such studies have taken place in Riyadh (Alsayed, 2013; Barnawi, 2017), the eastern region (Al-Khathami et al., 2013), and the western region (Al-Zahrani, Al-Qarni, & Abdel-Fattah, 2013; Maghrabi, 2012). However, there are serious limitations in the research based on country-level statistics, mental health epidemiology, or problems within a specific region. The latest major initiative in this regard was the Saudi National Mental Health Survey (SNMHS), a cross-sectional community-based, mental health epidemiological survey of a nationally representative sample of KSA citizens aged 15 to 65 conducted between 2011 and 2016 (Al-Subaie et al., 2020). However, no comprehensive findings of this survey have been published.

In KSA, only a few peer-reviewed journals focus on mental health, although the number of such journals is likely to increase as more funds become available for health research in the country (Qureshi et al., 2013). Abumadini (2019) conducted a thorough review of mental health research in KSA between 1975 and 2017 and found a total of 670 studies; this included a significant increase in numbers over the last twenty years, particularly over the last decade, with a peak of 110 studies published in 2016. There was also a sudden increase in the citation of KSA publications on mental health after 2010, probably due to the increased funding for education and research that began at that time (Abumadini, 2019).

The latest national atlas of mental health in the country noted tremendous progress having been made in terms of research; however, a persistent need to improve the situation further remains (Al-Habeeb et al., 2016). Abumadini (2019) further claimed that, despite the impressive progress made in mental health research in KSA, work in this area remains in its infancy; he recommended increased funding support from universities to researchers to help increase both the rates and quality of research on mental health at a national level.

1.5 Psychosis in relation to religious, cultural, and gender-related factors

The following sub-sections are intended to clarify essential terms and definitions required to discuss psychosis, as well as to examine various aspects of religion, culture, and gender insofar as these factors affect psychosis. This examination of the literature is informed by the main aim of this research, which is to understand KSA women's experiences of psychosis and nurses who care for them. This means that a deeper understanding of various aspects that affect such experience of psychosis in women is required.

1.5.1 Psychosis

The major reference used to classify mental disorders is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) (American Psychiatric Association [APA], 2013), and most of the definitions and classifications in this section relied on the latest edition of the DSM. DSM 5 (2013) defined psychosis as a process of impaired reality testing in individuals, accompanied by the presence of one or more of the following five domains: delusions, hallucinations, disorganised thinking (speech), grossly disorganised or abnormal motor behaviour (including catatonia), and negative symptoms (p. 87).

Psychotic disorders are complex, potentially chronic, and typically first diagnosed in people in their late teens and early to mid-20s (APA, 2013). Psychosis is a severe illness which leads to a major global disease burden, and it was ranked among the top 15 leading causes of disability worldwide as recently as 2016 (Vos et al., 2017). The general prevalence of psychotic disorders is 3.89 per 1,000 persons (Moreno-Küstner, Martín, & Pastor, 2018).

Psychosis was identified in DSM 5 (2013) as the defining feature of schizophrenia spectrum disorders, which in turn are listed as schizophrenia, schizo-affective disorder, delusional disorder, schizophreniform disorder, and brief psychotic disorder (p. 89). Postpartum

Psychosis (PPP) is classified more specifically as a brief psychotic disorder, where the onset of psychosis occurs during pregnancy or within the first four weeks postpartum (APA, 2013).

Psychosis also occurs in some people with bipolar disorder, during either manic or depressive episodes, as well as in some individuals during the major depressive episodes associated with serious depressive disorders (APA, 2013). DSM 5 (2013) also notes the relatively common co-occurrence of psychotic symptoms in people with neurocognitive disorders during either intoxication or withdrawal from substances, which may, in some cases, lead to it becoming a chronic sequelae of prior substance abuse. This is known as substance-induced psychotic disorder, and it is classified as a secondary psychotic disorder (APA, 2013).

Hallucinations, delusions, and negative symptoms, significant features of psychosis, are examined in more detail in the following sub-sections. The existing literature on the treatment of psychosis is then examined in a separate discussion.

1.5.1.1 Hallucinations

Hallucinations are defined in DSM 5 as sensory experiences unprovoked by external circumstances (APA, 2013). The typical experience of such hallucinations in psychosis is auditory; however, while this is a major symptom of psychosis, it also quite commonly occurs in a transient and benign form in healthy individuals (Maijer, Begemann, Palmen, Leucht, & Sommer, 2018). Auditory hallucinations are also not a modern invention: a number of famous historical figures reported voice hearing experiences, including Socrates, Joan of Arc, Mahatma Gandhi, Virginia Woolf, and Carl Jung (Smith, 2007). Auditory hallucinations are experienced by one in ten individuals in the general population across their lifetimes, with a mean prevalence rate of 9.6%; however, this prevalence appears to be significantly higher in children and adolescents, who report such experiences significantly more often than adults and the elderly (Maijer et al., 2018).

Hallucinations may occur with or without the individuals having insight into the hallucinatory nature of the experience; it is generally the absence of insight into a hallucination that defines it as a psychotic symptom for which reality testing is impaired (APA, 2013). While auditory hallucinations are the most typical manifestation of hallucination in psychosis, consumers may also have visual or other sensory occurrences (APA, 2013). Even auditory hallucinations are sporadic and simple in most psychotic episodes, however McGrath et al. (2015) showed that most individuals with psychotic experiences only had such hallucinations one to five times across their whole lives. Nevertheless, hallucinations, especially those that appear threatening or violent, may be particularly unnerving or stressful symptoms for individuals experiencing them (Longden, Madill, & Waterman, 2012).

1.5.1.2 Delusional beliefs and negative symptoms

Delusions are described in DSM 5 (2013) as fixed false beliefs and convictions held by an individual based on incorrect or false inferences about reality external to, or with reference to, themselves; these are characterised by the fact that they cannot be altered, even when contradictory facts are presented to the individual by others (p. 87). Such delusions are pathological where they are harmful and malfunctional, and may have significant negative impacts on an individual's wellbeing (Miyazono, 2015). Such delusions may take many forms, including persecutory, referential, somatic, religious, or grandiose (APA, 2013).

Another feature of psychosis is negative symptoms, which are defined in DSM 5 (2013) as being related to restricted emotional expression and avolition. The first term includes any reduction in the expression of emotion in the face, including reduced eye contact, as well as limited intonation of speech (prosody) and reduction in the movements of the hand, head, and face that normally give emotional emphasis to speech. Such effects may be further related to avolition, defined as a decrease in motivated self-initiated purposeful activities (APA, 2013, p. 88). Such negative symptoms may also, however, be secondary to many other conditions related to the psychotic experience, such as long-term institutionalisation, lack of environmental stimuli, poor social support, or even antipsychotic medication (Kirschner, Aleman, & Kaiser, 2017).

1.5.1.3 Treatment focus for psychosis

To achieve consumer recovery from psychosis, treatment approaches must focus on both medication and recovery-focused psychosocial interventions, with the latter tending to yield results which go beyond mere symptomatic improvement and stability (Correll, 2021). The combination must preferentially be started in the earliest phases of psychosis, as early access to treatment enables a shorter duration of untreated psychosis, which is associated with better symptomatic and functional outcomes (Howes et al., 2021).

Antipsychotic medication may be offered in either oral or injectable formats, although current preferences tend to the use of injectable long-acting antipsychotics to reduce the risk of treatment discontinuation, relapse, hospitalisation, and subsequent mortality (Kishimoto, Hagi, Kurokawa, Kane, & Correll, 2021). Importantly, mental health practitioners must strive to identify for each consumer the medication or medications that have the least, or at least the most subjectively tolerable, short-term side effects, to ensure that quality of life and everyday functioning are not adversely affected, therefore helping avoid medication non-adherence (Tandon et al., 2020). A range of supportive psychosocial interventions are recommended for psychosis, including individual and family psycho-education, individual and group psychotherapy, case management, skills training, and supported employment and education (Correll, 2021).

1.5.2 Religious and transcultural impacts on psychosis

Culture, as defined in DSM 5, refers to the systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations, which include language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems (APA, 2013, p. 749). This makes a review of the global literature on religious, spiritual, and cultural aspects of psychotic experiences essential to this work, as it is necessary to develop awareness of their important impacts before proceeding with an examination of the topics of research in the specific KSA cultural context.

The actual experience of psychosis is, at least in part, dependent on an individual's religious and cultural environment (Campbell et al., 2017). Cook (2015) affirmed that the religious content in delusions and hallucinations appears to be relatively common among consumers with psychosis. The DSM 5 takes into account the many ways in which cultural and religious backgrounds can interact within the diagnostic process of psychosis (APA, 2013). Delusions may be culturally specific, as seen in situations of accusations of witchcraft, or based in

specific rituals, with individuals potentially experiencing auditory hallucinations during religious experiences that other people may not consider unusual (APA, 2013). The extent to which hallucinations and delusions are interpreted as appropriate, benign, socially accepted, and normative within certain communities may be understood as a cause for variations in rates of distress resulting from such experiences (Fonseca-Pedrero et al., 2018).

1.5.3 Gender-focused studies on psychosis

To inform the current research, it is necessary to review studies of psychosis related to gender within the global context, given its focus on women's experiences. Seeman (2016) stated that gender is an essential factor in causing psychosis to take on unique forms; there is also an additional factor in this, in that postpartum ailments are naturally limited to women.

Exploration of the role of gender in the development of psychotic experiences has been limited (Haarmans, 2019). The available literature mainly focuses on the younger male population with psychosis to the exclusion of females to a certain extent (Chernomas et al., 2017). One possible reason for this domination of interest in males in the literature is the statistically earlier age of onset of psychosis in males and the subsequent focus on them in early intervention programs (Payne, Malla, Norman, Windell, & Brown, 2006).

In term of quantitative studies, gender is generally assumed to be a stable and objective epidemiological factor (Longenecker et al., 2010). However, some research has noted variances based on gender related to psychosis. Petkari, Mayoral, and Moreno-Küstner (2016) revealed that more men experience psychosis than women, although Avezuela et al. (2015) claimed that women experience delusions more frequently than men. The independent contributions of gender to the clinical courses and outcomes for consumers with psychosis remain unclear, and little evidence is offered in the literature concerning gender differences with regard to illness severity, although one study found that men experience more severe forms of psychosis than women (Petkari et al., 2016). Where women do develop psychotic

experiences, however, they tend to perceive with a higher sensitivity the discrepancies between their social roles as women and the gender-role norms and stereotypes that adversely affect them (Haarmans, McKenzie, Kidd, & Bentall, 2018). Nevertheless, Petkari et al. (2016) examined rates of seeking treatment across genders and found little difference in the use of services.

In terms of qualitative studies considering women's experiences with psychosis, little of the literature has unpacked this aspect. The exception is the work of Patricia Deegan (Deegan, 2002, 2007), who narrated her own experience of schizophrenia and recovery in the 1990s: she narrated the experience of illness in detail, telling a story of being an ambitious athletic teenager who had her dreams shattered by schizophrenia and related hospitalisations. Other studies in the last decade or so have focused on women's experiences of PPP (Engqvist, 2011; Hunter, 2013; McGrath, Peters, Wieck, & Wittkowski, 2013). This very limited scope, with its focus on postpartum ailments, was expanded somewhat to explore a broader range of psychotic disorders in a systematic review by Chernomas et al. (2017), which synthesised qualitative findings around young women's experiences of living with psychotic illness. Based on these synthesised findings from qualitative studies, two categories were identified: the complexity of living with psychosis and finding health, and the presence of harming and healing relationships in young women's lives (Chernomas et al., 2017).

Given the limited evidence available on gender and the paucity of women-focused studies, future research needs to be either gender-based or incorporate some gender-based analysis (Haarmans et al., 2018). The study of women's experiences of psychosis is particularly important with regard to developing understanding of these experiences, particularly in the context of the onset of young adulthood and its potential to affect multiple significant aspects of women's lives (Chernomas et al., 2017). Such research is also necessary for the development of appropriate psychological therapy for women with psychosis, based on clear

insights, which can target the impacts of gender-related psychotic symptoms (Haarmans et al., 2018).

1.6 The impact of KSA-specific religious, cultural, family, and community factors on women with mental illness

Based on the review of global literature on the impact of religion and culture on experiences of psychosis, it is also worthwhile reviewing how these factors affect mental health among women in the specific context of the current research (KSA). The following sub-sections include commentary on the effects of KSA religion, culture, and family on responses to mental illness among KSA individuals, followed by an examination of studies of mental illness, and more specifically psychosis, among KSA women. Further discussion then follows on how families and communities in KSA perceive and respond to women with mental illnesses, and how this may affect women.

1.6.1 KSA religious and cultural impacts on mental illness

The KSA community generally follows an orthodox and strict interpretation of Islam that affects various societal and relationship aspects and which significantly impacts individuals in their performance of their roles in the community (Ezzi, Teal, & Izzo, 2014). The holy book of Islam, the *Quran*, along with the *Hadith* (sayings regarding the prophet Mohammed) are used as the main sources of guidance in the daily lives of KSA individuals, and underpin all of the laws, knowledge, and spiritual experiences by which people live (Algahtani, Buraik, & Ad-Dab'bagh, 2017).

KSA's culture is, however, unique, being influenced by both these Islamic traditions and the large segments of its community that remain deeply rooted in regional and tribal traditions (Algahtani et al., 2017). Individuals are viewed mainly as extensions of their immediate and

extended families, which in turn are seen as members of a bigger tribe (Al-Krenawi & Graham, 2000). These religious and cultural beliefs and traditions in KSA tend to influence individuals' understandings of mental illness (Algahtani et al., 2017). KSA individuals generally perceive illness to be a test from God, with the purpose being to teach them patience and purify them of sin (Al-Mutair, Plummer, Clerehan, & O'Brien, 2014). Additional religion-adjacent supernatural concepts are also frequently applied to explain mental illness in KSA, including magic, malicious envy, the evil eye, or possession by *Jinn* (Badawi, 2016). The ascribing of illness to such factors is the main motive for the tendency for consumers to seek treatment from traditional faith healers or clergymen who apply faith-based techniques in an attempt to promote healing, a course that is frequently prioritised ahead of seeking professional mental health assistance in the early stages of mental disorders (Algahtani et al., 2017). Rahim and Al-Sabiae (1991) conducted a study into PPP in KSA women that showed a long average interval between the onset of psychotic symptoms and admission to hospital. These considerable delays can easily be attributed to the fact that consumers and their relatives usually seek help from traditional healers before seeking any professional medical attention (Zolezzi, Alamri, Shaar, & Rainkie, 2018).

1.6.2 KSA family responses to mental illness

The extended family structure is a powerful social unit in KSA culture; individuals seeking mental health treatment cannot generally be considered in isolation from their families (Algahtani et al., 2017). Koenig et al. (2014) reported that large and extended families typically live in the same home in KSA, and Islamic beliefs also suggest that individuals and families who provide care to the sick will receive special blessings. It is also an Islamic obligation to care for relatives, and this is especially true with regard to women, children, unmarried young adults, and the elderly, though it can apply to any family member (Algahtani et al., 2017). Although the extended family structure is protective and reassuring to a certain

degree, it is evident that this structure is also frequently a source of internal and external conflict, with individuals seeking increased autonomy and individuality (Algahtani et al., 2017). Koenig et al. (2014) asserted that in KSA, while the availability of mental health services may be growing, the composition and prominence of the local family unit still contributes to a lack of understanding of mental health problems and their treatment which prevents many people from seeking help for their loved ones. This arises from the belief that most care should still take place within the home, despite such care lacking specialist expertise (Koenig et al., 2014). Any strict application of Western mental health therapeutic interventions, which are likely to focus on occidental perspectives of individuality, autonomy, and the self without consideration of extended family impacts and influences, may not be practical or useful in light of KSA culture (Kirmayer, 2007).

There is also a tendency towards the imposition of stigma in KSA families regarding mental health issues, which in turn tends to impact responses to mental illness. KSA individuals tend to turn to their families first when they encounter problems with their mental health or personality changes; however, the stigma associated with such issues may negatively affect the dynamics of the help and support provided by these families (Algahtani et al., 2017). An examination of cross-cultural studies reported that stigmatising attitudes towards mental illness are more significant in collectivist cultures, such as those in the Middle East, than in individualistic cultures (Griffiths et al., 2006). Mental illness in KSA is also further associated with stigma due to the fact that such illnesses can affect the reputation and image of the family as a whole within the community (Algahtani et al., 2017). As a result, mental illness within a KSA family is often kept secret from those outside the family, including healthcare professionals, based on the fact that the stigma attached to mental health issues across the Arab world can lead to the families of consumers being rejected, isolated, and excluded from the broader community (Koenig et al., 2014). Saxena, Thornicroft, Knapp, and Whiteford

(2007) observed that this negative image of mental illness is a significant hurdle to people seeking effective treatment in KSA, while Farooqi (2006) also argued that feelings of guilt and shame around mental illness prevent family members from discussing their relatives' problems with anyone, including mental health professionals and physicians.

1.6.3 KSA women with mental illness and psychosis

Mental illness in KSA women has been broadly overlooked in the literature, with existing studies being both limited and highly specific to certain disorders such as depression and anxiety. One example of such focus is found in Alosaimi, Altuwirqi, Bukhari, Abotalib, and Binsaleh (2015), who noted a link between mental illness in women and certain physical conditions, including female infertility, which led to depression and anxiety in 36.9% of the women examined. Another example was provided by Almutairi et al. (2017), who examined the impact of help-seeking behaviour and partner support on postpartum depression among KSA women, and found that the prevalence of postpartum depression among women was very high at 25.7% compared with the 10 to 20% seen in developed countries. That study emphasised that depression was reduced by enhancing women's help-seeking behaviour and increasing partner support (Almutairi et al., 2017).

Studies of the prevalence of psychosis in women in KSA are even more limited. The most recent cross-sectional study, by Alosaimi et al. (2017), was conducted on individuals seeking mental health services at six hospitals in the five central regions of KSA. This study found that 45.5% of female inpatients and 20.6% of outpatients were diagnosed with primary psychotic disorders (Alosaimi et al., 2017). All other existing literature about women with psychosis in KSA is relatively old, and often even more limited. Rahim and Al-Sabiae (1991) examined the clinical profile of just one type of psychosis, PPP, taking long periods of untreated psychosis in women as a key variable. Shoeb and Hassan (1990) also studied the prevalence of PPP in KSA, and their findings were generally comparable to those observed in

Western epidemiological studies, with an incidence of PPP of around three per 1,000 births. Qureshi, Al-Habeeb, Al-Ghamdy, Abdelgadir, and Quinn (2001) took a more sociocultural perspective related to delusions of pregnancy among KSA women and discussed various sociocultural factors and consequences related to this type of delusion, making their study a valuable addition to studies of KSA women with psychosis.

1.6.4 KSA family and community responses to women with mental illness, including psychosis

KSA Islamic and cultural traditions, as noted earlier, have significant impacts on both the families of consumers with psychosis and the wider community, and this can specifically impact women's mental health on a day-to-day basis. Furthermore, the common occurrence of extended families complicates family dynamics, frequently leading to role confusion among women and interpersonal conflicts inside the family which increase emotional stress and strain on women in KSA (Qureshi et al., 2001). Various interlocking cultural and religious factors are associated with significant distress, mental illness, and altered mental states in women, and these may both lead to the onset of various mental disorders and impede recovery from such illnesses (Qureshi et al., 2001). Furthermore, many women adhere to traditional values regardless of their level of education, living in communities where they continue to be undervalued and controlled by men, despite government efforts to increase their standing in the community (Shalhoub-Kevorkian, 2005). This discrimination pushes women into bearing more significant psychological burdens than men, with the latter nevertheless working hard to silence women whenever they attempt to express and relieve themselves of these burdens (Shalhoub-Kevorkian, 2005).

KSA families may have several different responses to women with mental illness. Some families take active steps to exclude women from any contact with the outside world, with the

reasons for such exclusion being those discussed by McCrae, Sharif, and Norman (2019), who noted that families in KSA feel stigmatised for having a member with mental illness, especially when that person is a woman. Gearing, Brewer, Schwalbe, Mackenzie, and Ibrahim (2013) conducted a study in Jordan (an Arab nation bordering KSA) which suggested that friends, as well as family, often reject women with psychosis based on this cultural approach. Men with psychosis were also reported as being more likely to lead successful lives than women with psychosis in this context, which indicates that gender plays a role in social stigma in such cultures (Gearing et al., 2013). This increased stigmatisation of women with mental illness in KSA is based on the fear of shame, and it is escalated by negative views in the community of mental illness which are reinforced by ongoing negative media portrayals of mental illness (McCrae et al., 2019).

The community and families in KSA also have significant impacts on women with mental illness seeking treatment. KSA women, along with many other Arab women, may face greater barriers to seeking mental health treatment than men, mainly based on perceived stigma and negative community judgments of mental health care-seeking (Al-Krenawi, Graham, Al-Bedah, Kadri, & Sehwal, 2009). This stigma may also be related to concerns about the possible detrimental effects on marital prospects (Saxena et al., 2007) or, where women become ill once they are married, to fears of the illness increasing the possibility of divorce or of the husband taking another wife (Al-Krenawi & Graham, 2000; Al-Krenawi et al., 2009). Men who practice polygamy may more readily cause marital disharmony and create stressful situations for their wives, and these stressors might also impact women with mental illness (Algahtani et al., 2017). Rahim and Al-Sabiae's (1991) work showed that some delusions among women in the KSA context actually reflected genuine concerns based on a real possibility of their husbands taking additional wives. When KSA women experience mental illness, the practical impacts can be particularly traumatic, as these may include the

dissolution of marriage or a wife being sent back to her parents until she recovers (Rahim & Al-Sabiae, 1991). According to Qureshi et al. (2001), this is a result of husbands claiming that *Sharia* gives them the right to divorce women who display mental unfitness or similar incompetency. Arab women face unyielding social constructions that impede their access to mental health treatment (Shalhoub-Kevorkian, 2005). Nevertheless, Gearing et al. (2013) argued that access to mental health services for Arabic youth, both males and females, in Middle Eastern countries, is improving, perhaps because the younger generations does not accept stigmatisation of mental illness in the same way.

1.7 The researcher's motivations for this research project

Since 2007, I have worked as a teaching assistant in the Mental Health Nursing Department of the KSA College of Nursing, which offers general nursing degrees. Throughout these years, my teaching experience with students has focused on their training in mental health hospitals, where they are expected to provide care for many women. This training was limited to work with women, as attendance at men's facilities is not permitted for female students due to the rules segregating the genders, including both consumers and professionals, within hospitals, based upon both religious and cultural considerations.

As I had the requisite basic training to facilitate offering support to these students, I was able to teach them how to apply mental health nursing care strategies to multiple types of illnesses. The resulting training also included ways to handle the development of relationships between the students and their consumers, and how to apply various nursing principles to women with various conditions.

Teaching students about psychosis was among the most challenging aspects from my perspective, as any attempt to understand the experience of psychosis through the development of therapeutic relationships to help women recover requires the input of a great

deal of effort. My initial step was generally to encourage students to try to communicate with the women concerned, to start developing an understanding of their experiences while initiating good working relationships. Once students committed to this phase, understanding their consumer became much easier, and they reported that many women narrated rich experiences to them. As a mental health nurse, my knowledge and experience of understanding women with psychosis made these narratives intriguing and inspiring to me, and this was the trigger for my motivation to research women's experiences with psychosis in more depth.

The most inspiring moments arose when women with psychosis could share their recovery experiences and help others learn how to accept and adapt to the illness. At the same time, I developed a strong desire for dedicated and established media platforms that might allow the consumers' voices to be shared with others to help support recovery from psychosis across a broader audience. One powerful global example is the network discussed by Romme and Morris (2013) which has been built over several decades and across more than 20 countries and cultures and features the shared experiences of those who have heard voices and their families. Some participants have recovered and no longer hear voices, while others have learned to live with the voices, and others shared therapeutic approaches which focus on accepting these voices (Romme & Morris, 2013). Examining this network during my teaching allowed me to reflect on the issues I was concerned about regarding common understandings of psychotic experiences. I realised that expanding my understanding of psychosis among KSA women to provide better nursing care to individuals with psychosis based on solid research was a necessary next step for me.

The turning point was my decision to study psychosis in 2008, when I pursued these interests by completing a Master's degree. My thesis examined the effect of applying psycho-educational interventions to KSA women with schizophrenia, and the results demonstrated

that educational sessions tended to improve both insight and medication adherence among women with schizophrenia (Al-Yahya, 2014). Although my understanding of psychosis was further developed, I felt impelled to further study of women's experiences of psychosis in the KSA context.

The current research is an attempt to explore women's experience with psychosis and how they are cared for by nurses to develop a comprehensive understanding of the psychotic experience, informed by the lens of my own mental health nursing practice. The choice to explore these lived experiences of psychosis as the focus of my Doctor of Philosophy studies arose for various reasons. My initial review of the literature convinced me that a deeper understanding of psychosis and its impacts on individuals could be reached by investigating the experiences of psychosis from a consumer perspective (McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, 2013). I was also keen to set my study in KSA, as no similar studies have been carried out in the country, and several unique cultural factors related to the KSA context require serious consideration.

I am aware that the topic, with its focus on KSA women diagnosed with psychosis, will be seen as sensitive in some quarters. As discussed in the previous section, many myths still surround mental health disorders, supported by some challenging cultural norms around women with mental illness in KSA. These cultural norms are often the cause of social stigmatisation of women with mental illness (Saxena et al., 2007). My hope is that this research may assist the much-needed reduction in the stigma surrounding people with mental illness, particularly women with psychosis, based on it allowing these women's voices to be heard.

This research, based on exploring the experiences of both women with psychosis and their nurses, should also help develop a deeper understanding of nursing care provision for women with psychosis which may support significant improvements in mental health nursing care,

based on the scientific approach used in the research. I also believe that an examination of nurses' experiences, including their understandings of, attitudes to, and practices while providing care to, individuals with mental illness in KSA, particularly consumers with psychosis, is essential, as by acknowledging nurses' perspectives, consideration can be made of the education and training needs reflected in those perspectives, with any improvements and amendments helping them to provide better care to consumers.

By undertaking this research, I hope to develop a better understanding of the experiences of women with psychosis and how they are cared for by nurses. I also hope to foster improved nursing care approaches for women with psychosis, promoting advances which will improve local, national, and international mental health care.

1.8 Thesis structure

This thesis is presented in 12 chapters. The chapters have been structured to contribute to and address the underlying thesis inquiry, which relates to an exploration of the experiences of KSA women with psychosis and the nurses providing care to those women.

Chapter One provides the context of this research, including the research intent and the significance of the project. The KSA mental healthcare system is discussed in general terms, followed by a formal definition of psychosis and an examination of the effects of religion, culture, and gender perspectives on psychosis. A further explanation of the impact of religious, cultural, and familial issues on individuals with mental illness in the KSA context, particularly women with psychosis, is provided. The researcher's background, motivations, and interest in researching women with psychosis and mental health nursing in KSA are discussed.

Chapter Two presents a brief review of the literature on advancing mental health nursing practice for consumers with psychosis in a KSA context. Some of the material in this chapter

was previously published in the *Journal of Nature and Science of Medicine*. The remaining part of the chapter offers a brief reflection on that paper in the research context.

Chapter Three offers an integrative review of the experience of psychosis and recovery from a consumer perspective. This integrative review includes a discussion of the search strategy and key terms used, the results and a discussion of those results, and a conclusion. Some of the material in this chapter was previously published in the *Journal of Psychiatric and Mental Health Nursing*, and further commentary sections have been added and linked to the research aims.

Chapter Four provides a further integrative review of nurses' understandings of and interventions for consumers with psychosis. Commentary sections are added, linked to the research aims, as appropriate. This commentary links the aspects of the review focusing on nurses' understandings of psychosis and their interventions to the current research inquiry. A discussion of gender and culture is also included through the lens of the review findings and the aims of the current research. The researcher's position in deciding on the design of this research is also highlighted.

Chapters One to Four offer the context and background of the thesis, establishing the need to examine such matters in the KSA mental health context, focussing on cultural and gender-based factors. Based on the identification of the significant gaps in the KSA context, the application of qualitative research to women's experiences of psychosis and nurses' experiences of providing care to women is further supported by a review of existing qualitative literature in these areas. Identification of the gap in knowledge in existing qualitative research informed the researcher's decision regarding the design of this research, which is based on van Manen's (2016) methodology.

Chapter Five describes the hermeneutic phenomenology used as the research methodology in this thesis, including a description of the philosophical orientation of van Manen's (2016) phenomenological methodology, which acts as the selected paradigm for this research. The reasons for choosing this paradigm are highlighted, and an explanation of how this methodology sits within mental health nursing disciplinary perspectives is offered.

Chapter Six describes the research method used, including data collection, management, and analysis, and offers a description of the participants. Some reflection is also presented on the researcher's positionality in applying this method, including the related challenges and her experiences and thoughts about overcoming these challenges.

Chapter Seven reports on the researcher's position regarding analysis of the data gathered from women with psychosis and nurses in KSA mental health facilities. The researcher's experiences and thoughts concerning the analysis of the accounts gathered, the styling and writing up of the analysis, and the development of researcher self-confidence are all discussed, and a mapping of the analysis chapters is then offered.

Chapters Five to Seven link the front- and back-sections of this thesis. Based on the choice of van Manen's (2016) methodology to support this thesis inquiry, this methodology is described in terms of its support of the research aims. An outline of the method of application is also provided, particularly of the researcher's challenges in collating and analysing the findings; the decisions which emerged are explained and justified. The choice to apply a qualitative approach to a study of women and nurses in the KSA context was particularly challenging because of the unfamiliarity of the method and the paucity of existing studies on both qualitative methods and the selected participants in this context. Prior to the analysis chapters, a justification of the researcher's decisions concerning the inquiry is essential.

Chapter Eight presents the first findings from the nurses' accounts, focusing on the major theme of nurses' lived experiences of caring for women with psychosis in mental health facilities and spaces in KSA. This analysis applies van Manen's (2014) lived space as the primary lens for interpretation.

Chapter Nine further explores nurses' lived experiences and investigates their understandings and emotions related to caring for women with psychosis in KSA. This analysis is based mainly on the lived body, as devised by van Manen (2014). Two main themes emerge, one exploring nurses' understandings of psychosis, with the other reflecting on their emotional labour experiences while caring for women with psychosis.

Chapter Ten mainly uses the lived self-other existential by van Manen (2014) to analyse the experiences of nurses caring for women with psychosis in KSA. The first theme explores nurses' experiences of communicating with consumers' families, while the second theme explores their other relationship-based experiences, and the final theme reflects their experiences with stigma while providing care to women with psychosis.

Chapter Eleven presents a hermeneutic analysis of women with psychosis accounts, based on the methodology developed by van Manen (2016). Three themes are identified regarding their experiences: their experiences with first episode psychosis; their experiences on admission or follow-up in a mental health facility; how they experience psychosis after discharge while living in the community.

Chapters Eight to Eleven are the analysis chapters, and the style used to write this analysis is discussed in Chapter Seven. These chapters also integrate several aspects found in the context and literature review chapters, with the new insights adding to existing knowledge of what it is like to be a KSA woman with psychosis and to be cared for by nurses. These extensions of knowledge are gathered and integrated in Chapter Twelve, the final chapter.

Chapter Twelve brings the research together, including an overview of the research inquiry's accomplishments. This chapter illuminates the contribution of these findings to the thesis' inquiry exploring women's and nurses' experiences and integrating the literature previously examined with these findings to highlight the new insights revealed in the thesis. Several suggestions for improvements in education, practice, policy, and education are made, and the limitations of the research are also outlined.

Chapter Two: Mental Health Nursing Care for Consumers with Psychosis in KSA

2.1 Introduction

This chapter offers a review of the literature on mental health nursing care for consumers with psychosis in KSA. It is necessary to examine the KSA literature related to the provision of care to consumers with psychosis in this context, as the aim of this research is to explore specific facets of this context, particularly the experiences of women with psychosis in KSA and the experience of offering nursing care to women. This chapter discusses the importance of such a literature review before offering a published paper on a brief review of mental health nursing practices for individuals with psychosis in KSA. The discussion following the review is based on the contribution of the paper to this thesis.

2.2 Providing mental health nursing care for consumers with psychosis in KSA: An overview of the published paper

The text of the published paper supports one aim of this research in particular, the exploration of KSA nurses' experiences of providing care to women with psychosis. The following sub-sections introduce and comment on the paper.

2.2.1 Introduction to the paper

This paper offers a brief review of the latest literature at the time on the mental health nursing care offered to consumers with psychosis in KSA and highlights several gaps in the literature in relation to the practices of nurses providing care for consumers with psychosis in this context.

2.2.2 The significance of the paper

As one aim of this research is to understand nurses' experiences of care provision for women with psychosis in KSA, the gaps in nursing practice for psychosis identified in the paper helped to develop an understanding of the new insights required and the factors which need to be examined in the wider research project in KSA.

2.2.3. Commentary

Relative to the published paper, a literature search to review research about nursing care for consumers with psychosis in KSA was attempted. However, as no literature was found which directly related to this context, the researcher presented her discursive perspectives on such care as an educator in mental health nursing. The researcher's two supervisors supported the concept and argument and revised and approved the draft paper sufficiently to warrant co-authorship. An examination of how contemporary global nursing care can be translated to reflect the KSA context is presented, particularly regarding the aspects of education and practice. There is a gap in research on women with psychosis in KSA, and this thesis requires the gap to be examined as it specifically aims to develop women-focused research. This type of research is also emphasised in the recommendations in the paper.

**Advancing Mental Health Nursing Practice in the
Kingdom of Saudi Arabia: Rethinking Nursing
Care for Consumers with Psychosis**

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Dr. Ian Munro

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Declaration for Thesis Chapter Two

Declaration by candidate

In the case of the paper entitled: Advancing Mental Health Nursing Practice in the Kingdom of Saudi Arabia: Rethinking Nursing Care for Consumers with Psychosis, which appears in Chapter Two, the nature and extent of my contribution to the work was the following:

Nature contribution	Extent of contribution (%)
Concept development, research, original ideas, writing up.	70%

The following co-authors contributed to the work.

Name	Nature of contribution
Dr. Ian Munro	Draft review and editing.
Assoc. Prof. Cheryle Moss	Draft review and editing.

The following acknowledgement is made.

Professor Wendy Cross	For early contributions and ideas.
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The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Review Article

Advancing Mental Health Nursing Practice in the Kingdom of Saudi Arabia: Rethinking Nursing Care for Consumers with Psychosis

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Abstract

In this paper, the current mental health nursing care to recovery for consumers with psychosis in the Kingdom of Saudi Arabia (KSA) has been presented through one author's experience. This discussion showed major gaps in the practice. To advance this practice, it was important to understand the background of contemporary research about the role and work of nurses caring for consumers with psychosis and assisting with recovery. In addition, the perspectives of mental health nurses about their practice of care for psychosis globally were also provided. Finally, these global matters had been translated within the KSA context into advance mental health nursing care and recovery for psychosis in the aspects of education and practice. The emphasis on gender-focused research as an imperative need has been recommended.

Keywords: Nursing, psychosis, recovery

INTRODUCTION

The World Health Organization states that around 24 million people globally experience psychosis, and this tends to be a chronic and pervasive condition.^[1] The Diagnostic Statistical Manual of Mental Disorders-5 states that psychosis is the most significant mental illness.^[2]

All professionals working in mental health services play an important role in ensuring that consumers have a pathway to necessary support consumers with a mental illness; however, mental health nurses must often take on responsibility for providing additional support.^[3] A nurse's role in caring for people with psychosis is to alleviate suffering, aid recovery, and minimize the risk of relapse.

THE AIM OF THE PAPER

This paper aims to examine recovery care for people with psychosis in the Kingdom of Saudi Arabia (KSA), incorporating recovery models for psychosis into this context. There is a pressing need to reform and develop mental health practice in the KSA, especially in terms of working with consumers as they recover. This requires a close examination of

contemporary mental health practice to allow the development of models that best fit KSA culture. Advancement of mental health nursing care will enhance client care and practice through research within the health-care environment and advance education in this area.

Contemporary mental health nursing care for people with psychosis: General overview

Mental health nursing in the KSA could be advanced, if Western mental health nursing literature was used to develop an understanding of consumers' experience of psychosis and recovery. However, this experience needs to be adapted to meet the needs of KSA culture. Contemporary mental health nursing within Western literature for people with psychosis focuses on two major aspects: nursing roles and interventions

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for psychosis; these are also accompanied by several factors to support nurses in their roles.

A nurse's role in caring for people with psychosis is to help in relieving symptoms, assist recovery, and minimize the risk of relapse.^[2] These tasks are in part addressed through the development of an effective therapeutic relationship and skillful assessment of the consumer's needs, including risk identification to maximize health outcomes while also collaboratively working with family and carers.^[3-5] Interventions are more important in the early phases of psychosis as nurses identify symptoms and apply ongoing assessments;^[6] failure to conduct timely interventions could lead to consumers suffering longer durations of untreated psychosis, leading to an increase in anxiety and stress levels for staff trying to working with a consumer presenting with severe psychotic episodes.^[3] Psychosis can also affect nurses' relationships with consumers; it has been reported that therapeutic relationships with consumers are the cornerstone of their work, especially during the recovery process, where they take on the role of empathic listeners guiding consumers to recovery.^[7]

The development of support allows nurses to fulfill their roles and to grow capacity when working with consumers with psychosis effectively; nurses need support throughout this process, and this can be achieved through clinical supervision: an important process in nursing care. Intensive mental health training and peer support are significant supports that help nurses manage potential anxieties arising from working with consumers with psychosis.^[1]

Engagement of consumers with psychosis within treatment

Within the first author's experience of some KSA mental health units, she has seen little engagement with treatment plans from nurses with consumers, despite such engagement being essential in mental health plan. The chronic nature of psychosis requires continuous engagement from both consumers and treatment team members, and mental health nurses playing a pivotal role in such teams.^[8] Mental health nurses utilize a holistic biopsychosocial model of care, involving consumers in education to encourage to self-manage, as well as offering spiritual support. The importance of the consumer's perspective and their wishes must be emphasized in any treatment decisions.^[9]

The global context of nurses working with consumers in their recovery from psychosis

A global literature overview is offered here to give an idea of the way, in which nurses conceptualize recovery and what factors they identify as helping or hindering recovery including strategies to facilitate recovery. Within KSA, the knowledge and experience of nurses working with consumers with psychosis are lacking and needs to be improved.

A sense of hope with regard to consumers' recovery and well-being offers motivation for nurses to include in their

practice.^[3] Kaewprom *et al.* claim many nurses conceptualize recovery from psychosis as a gradual change and improvements in consumer thoughts and behaviors.^[10] Nurses identify facilitators of recovery, which include supportive families and communities.^[5,11-14] Nurses viewed stigma toward consumers with mental illness as a significant barrier to recovery.^[10]

To support and facilitate recovery with consumers, nurses targeted strategies such as presence intervention.^[13] Being present with consumers facilitates recovery producing a calming environment, building relationships, and allowing bonding, providing consumers with hope for recovery. Another common strategy is working behind the scene that means working around the consumers with a little awareness of consumers. The nurses use an invisible network of contacts and discussions with colleagues or with consumers' families about how consumers were managing activities of daily living, symptom management, and medication compliance.^[13]

Current mental health nursing practice for consumers with psychosis in the Kingdom of Saudi Arabia

At present, there is no research examining mental health nursing (MHN) and consumers with psychosis in the KSA, as this is in its infancy. By examining nurses' experiences of caring for consumers with mental illness identifies gaps in their understanding of mental illness. In addition, no mental health nursing research in the KSA has specifically examined psychosis and recovery, presenting a gap. Given the lack of current research, the first author has chosen to write about her personal experiences as an educator in mental health nursing as a way of identifying current practice. In addition, personal reflections based on observation and discussions with nurses about current practice within mental health nursing will be discussed.

Throughout the first author's experience training undergraduate nurses in mental health units, she has found shared issues emerging from nurses working within these units. In the KSA, there is no specialized postgraduate mental health nursing degree; the nurses who first author has met have held a mixture of diploma and bachelor's degrees in general nursing; very few have any form of specialized degree in mental health nursing. Some nurses had no advanced specialized training in mental health nursing before their exposure to consumers, raising the concern about their limited understanding of mental illness or psychosis.

Some units have nurses who are expatriates who do not speak Arabic well. This creates a communication gap with consumers, given that communication is central to therapeutic communication, such poor communication can create a tense atmosphere. More importantly, consumers feel they are not understood, and their needs are not being met.

Finally, nurses in these units do not have clinical supervision; this is absent across the country. This is a major concern, as nurses could use a trial and error method and not drawing upon evidence-based practice.

Translation of contemporary mental health nursing into the Kingdom of Saudi Arabia context

Drawing upon the first author's experiences of mental health nursing in the KSA, comparing it with contemporary mental health nursing recovery principles, there is a clear need and fit within the KSA culture.

ADVANCED EDUCATION FOR MENTAL HEALTH NURSING

Currently, there is no postgraduate mental health nursing degree in the KSA, while there are aspects of mental illness in all undergraduate mental health courses, this is inadequate to address the needs of the mental health services and consumers; therefore, there is a need to develop a postgraduate mental health nursing course. The postgraduate course must use principles of mental health recovery to improve mental health nursing care for people with mental illness.

ADVANCED MENTAL HEALTH NURSING PRACTICE

The KSA mental health system should develop in-service education or training for nurses working with consumers and their psychosis, developing practice guidelines to assist nurses working in mental health facilities. These guidelines should be tailored to meet the specific needs of various mental illnesses, including psychosis, and must consider incorporating religious and cultural social norms into the nurses' care. One KSA example is the concept of the evil eye, which is also seen in other cultures such as Greek and Italian rural society.^[15,16] The idea of the evil eye is conventional in Saudi society, despite being deemed eccentric by some mental health practitioners; this underpins the need to understand cultural considerations to be accounted for in any mental health nursing practice.

To decrease the problem of misunderstandings and to facilitate communication between nurses and consumers, expatriate nurses should be required to undertake Arabic courses. Another solution would be employing additional Arabic-speaking nurses in mental health units. In addition, the nurses' practice urgently requires the establishment of clinical supervision for nurses within the KSA mental health system. Collegial supervision could be sufficient to achieve proficient nursing care. There is also a pressing need for more planned decision sharing between consumers and nurses in relation to treatment plans; this is a central element of recovery.

Within the KSA context, there has been no research that has examined recovery models applied to either mental illness in general terms or psychosis more specifically. This is a gap in mental health practice that must be addressed in terms of developing a model of recovery suitable for the KSA context which can be applied within mental health units. Once a model for recovery is developed, there is a need for education programs for both consumers and carers, along with nurses and other health-care staff, so they are informed about psychosis and the various approaches that promote recovery. In the broader community, some individuals in KSA stigmatize psychosis and other mental illness, which does not

assist consumers in their recovery. To combat and breakdown these barriers, flexible community education programs that incorporate media information either online or other media to give education about mental illness should be developed and delivered to the community.

GENDER-FOCUSED PSYCHOSIS STUDIES

Understanding the impact of gender is an important recommendation for the advancement of mental health nursing practice in the KSA. Within the KSA context, Almutairi noted the need for further study into the mental health of women, as this is vital for the future of mental health services.^[17] Gender-specific psychosis experience has not been explored through qualitative methods, only through quantitative research. One example was a study that found the duration of untreated psychosis in women was longer than in men in the KSA, suggesting that seeking mental health treatment is delayed for women. This may occur because a husband might believe that it is better for the family to keep his wife's illness a secret to preserve his standing in society, as this could affect the likelihood of marriage for any children.^[18] This is adding up of a stigma that stops women from seeking treatment, which reported about Arab women with mental illness.^[19]

Al-yahya examined the effects of psychoeducational intervention in terms of increasing women's insight into their illnesses and improving medication adherence among women with schizophrenia in the KSA.^[20] Although the study reported improved insight and adherence to medication regimens in women after such interventions, it failed to examine any gender-specific issues. Studies related to women with psychosis in the KSA remain limited, and work in this area needs to be amplified.

CONCLUSION

This paper is written as an opinion, as it is important to provide an understanding of the consumers' experience of psychosis and mental health nurses providing this care. Raising the context of psychosis in the KSA, examining the cultural perspectives and gender-based studies shows that there needs to be more consideration and exploration of this area. To date, within KSA, there is no study examining nurses working with mental health consumers and providing psychosis care, depicting a gap in psychosis and mental health nursing research in this country; therefore, to address this gap is essential. This must also address the educational needs about contemporary knowledge of mental health nursing, commencing with increasing the content of undergraduate mental health nursing and the development and offering a postgraduate degree in mental health nursing.

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Conflicts of interest

There are no conflicts of interest.

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2.3 Reflections on the published paper in relation to the current research

The published paper was concerned with mental health nursing care for consumers with psychosis in KSA. As no previous literature in this specific context existed, this factor was discussed in the paper, and the researcher then presented her own experiences and perspectives as an educator in mental health nursing, to develop evidence to support the paper's aims. This process highlighted the extensive gap in the literature, which this thesis aims to reduce through its exploration of nurses' experiences of providing care to women with psychosis in KSA. The paper also recommended addressing the specific gap in gender-focused studies in this context, specifically in relation to women with psychosis; the direction of the current research is therefore intended to allow it to add to existing knowledge in this area.

In the paper, several points are raised about KSA mental health nurses' roles in providing care to consumers with psychosis. Since knowledge about what KSA nurses know and how they act with consumers with psychosis is limited, as an additional commentary to the paper, it is worth examining any further information on mental health nurses' standards of practice around the world. This discussion begins with a definition of mental health nurses in terms of their work and qualifications. The nurses' basic knowledge which they require to work in multidisciplinary teams is highlighted, and their basic general nursing backgrounds, their roles as mental health nurses, and their expanded roles as nurse practitioners are revealed. Nurses' roles and their interventions with consumers with psychosis are then described, although only briefly, as these were previously reviewed in the paper in the KSA context.

2.3.1 Mental health nurses

A mental health nurse is:

A registered nurse who holds a recognised specialist qualification in mental health [nursing]. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual. (Australian College of Mental Health Nurses [ACMHN], 2013, p. 5)

Mental health nurses therefore perform a wide range of roles, functions, and activities, from promoting optimal mental health, through preventing physical and mental ill health, to providing therapeutic interventions (ACMHN, 2016).

2.3.2 Basic qualifications of mental health nurses

To gain credentials to work as a mental health nurse, nurses are studying for specific qualifications in Western countries. In Australia, for example, such nurses must hold several qualifications, including a current licence to practice as a Registered Nurse (RN), a recognised specialist or postgraduate mental health nursing qualification, and either at least 12 months experience since completing their specialist or postgraduate qualification or more than three years of experience as a RN working in mental health (ACMHN, 2016). Similarly, a Nursing and Midwifery Council (NMC) (2018) accredited nursing degree or diploma is required to qualify as a mental health nurse in the UK. Nurses must complete pre-registration nursing degrees or nursing degree apprenticeships delivered by an NMC- approved education institution, and renew registration every three years (NMC, 2018). In the United States, any RN may practice mental health nursing as a Psychiatric-Mental Health Nursing Registered Nurse. However, the preferred level of education is at the bachelor level, alongside accreditation by the American Nurses Credentialing Centre (American Nurses Association, 2013).

As stated in Chapter One of this thesis, to work in mental health, nurses in KSA must hold a Bachelor's degree or Associate Diploma in nursing and be licensed to practise as a general nurse by the competent authority (MOH, 2021a). This credentialing means that any RN can work in mental health without prior mental health education or even any practical training in working with mental health consumers. This issue can present a gap in the practice of nurses working with mental health consumers in this context, particularly with consumers experiencing severe illnesses such as psychosis, as nurses generally begin this work without any specialist education.

2.3.3 Basic practice skills and knowledge among mental health nurses

Mental health nurses' practice is based on the standard foundational parameters of RNs practice and standards of care for consumers. An example of such standards of practice for RNs in Australia offers seven standards: 'thinks critically and analyses nursing practice; engages in therapeutic and professional relationships; maintains the capability for practice; comprehensively conducts assessments, develops a plan for nursing practice; provides safe, appropriate, and responsive quality nursing practice; evaluates outcomes to inform nursing practice' (Nursing and Midwifery Board of Australia, 2016, p. 2).

To apply these nursing standards of practice in general or specialist practice, including in the mental health context, Ashelford, Raynsford, and Taylor (2019) indicated that nurses should have a basic knowledge of the pathology of illnesses to inform their skills of clinical assessment, care, management, and clinical decision-making in practice. As part of offering holistic care to consumers, such knowledge will enable nurses to communicate and collaborate effectively with multi-professional teams and allow them to work with consumers to promote their health, facilitate early diagnosis, and stimulate recovery (Ashelford et al., 2019).

Nurses should achieve adequate levels of collaborative multi-professional practice. Inter-professional education can help nurses obtain the knowledge and competency to support the professional roles of others to improve consumer outcomes and create a holistic caring environment (MacDonald et al., 2010).

Therapeutic relationships are essential in mental health nursing. Peplau (1991) insisted that mental health nurses must be aware of different phases of their relationships with consumers and recognise the different roles of nurses during the development of such relationships.

During these therapeutic relationships, the mental health nurse should strive to understand the consumers' experiences of symptoms as framed by their thoughts, feelings, and actions (Merritt & Procter, 2010).

One final crucial role of mental health nurses is clinical supervision. A review conducted by Howard and Eddy-Imishue (2020) spoke of the effectiveness of clinical supervision in offering better coping skills, improved job satisfaction, and reduced stress for mental health nurses.

The roles mentioned above are just some of the many essential roles of mental health nurses, which all require a basic knowledge of specific skills for nurses to work in their roles smoothly in teams with different specialties. Alasmee (2020) examined KSA nurses' perceptions of their roles in inpatient settings. Nurses there tended to focus on consumers' physical and safety needs more than their mental health needs, which might be related to low nurse education levels and a lack of resources to support their practice (Alasmee, 2020). This study adds further understanding of KSA nurses' practice in mental health, as physical or custodial care can be linked to the basic qualifications of nurses mentioned earlier, which is limited to general nursing education. However, more insights are required to understand how they experience these roles in mental health settings. The present research may help explore the roles of KSA nurses while providing care to women with psychosis, and through

understanding their experiences, more insights might be revealed about the impact of education and support resources on their care provision.

2.3.4 Advanced mental health nursing roles

The roles of mental health nurses working with mental health consumers around the world have extended beyond the traditional; recent discussion of the concept of expanded roles tends to indicate the Nurse Practitioner (NP) role (Smallwood, Pidgeon, & Kemp, 2004). NPs undertake further education, usually at the postgraduate level, to enable them to practice at an advanced level and to make autonomous decisions regarding clinical diagnosis and treatment (Horrocks, Anderson, & Salisbury, 2002). The postgraduate qualification required for this differs between countries. In Australia, a qualification at the master's level, with specific content of pharmacology is generally recognised as a minimum qualification (Elsom, Happell, & Manias, 2007). NPs in Australia have an expanded scope of practice in the mental health specialty, being recognised by peers, colleagues, and service providers as offering clinical leadership and expertise to the mental health sector (ACMHN, 2016). NP leaders offer improved coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate mental health promotion, early intervention, and, where needed, wrap-around service provision (Morse & Procter, 2011). Some mental health NPs also act to ensure that consumers, families, and carers receive further education on relevant issues, as well as offering consultation, advice and support to facilitate adherence to medication and other treatments and the promotion of social inclusion and social connectedness for consumers (Morse & Procter, 2011).

Australian mental health NPs have also informally extended the role of the nurse into many additional areas, such as the prescription of a limited range of pharmacological agents, referrals to specialists, the ordering of diagnostic tests and procedures, and admission and discharge rights (Elsom et al., 2007). Mental health nurses in UK have also taken on

expanded roles which support nurses applying independent decision-making with regard to compulsory detention as a way to find the least restrictive option for the consumer and to carry out work which only social workers were able to do previously (Coffey & Hannigan, 2013). In KSA, however, no research has been reported to date on advanced practice among mental health nurses, which may indicate the lack of specialist qualifications for nurses assigned to work in mental health settings.

2.3.5 Mental health nurses' roles in managing psychosis

It is well worth attempting to understand nurses' roles in managing psychosis, as this research focuses on an exploration of the experiences of nurses while providing care to women with psychosis. While the integrative review in Chapter Four presents a qualitative literature review of nurses' understanding of and interventions in psychosis, highlighting nurses' roles in this sub-section should help develop an understanding of the extent of nurses' practice in managing psychosis. As presented in the earlier paper on advanced KSA nursing practice for psychosis, there is a gap of knowledge about nursing in that context. A description of nurses' roles may add knowledge which may inform the later understanding in this research of KSA nurses' experiences of care during the analysis of their personal accounts.

As a basic knowledge of pathology in terms of mental illness is important for mental health nurses, as discussed earlier, it must also play a role in managing psychosis and its symptoms, as indicated by Townsend and Morgan (2018), as a basis for the development of evidence-based knowledge. This knowledge includes performing an initial examination to identify the presenting symptomatology, such as delusions, hallucinations, and negative symptoms (Townsend & Morgan, 2018). With this knowledge, nurses can begin to understand that people with psychosis live in a frightening, unreal world and may have difficulty distinguishing reality from delusions and hallucinations: everything they feel seems real to them (Pinho, Pereira, & Chaves, 2017).

In the presence of delusions, the nurses' role includes the provision of a safe and therapeutic environment to consumers, particularly those in an acute state of confusion (Bulechek, Butcher, & Dochterman, 2008). Townsend and Morgan (2018) noted that, in the presence of delusions, nurses must demonstrate that they accept the consumer has a certain belief, while making it clear that they should not share the belief. Nurses should also reinforce reality by talking about things and people that are real, helping the consumer avoid ruminant thinking focused on false beliefs (Townsend & Morgan, 2018).

The main nursing role in situations of hallucination is to promote the safety and comfort of the consumer, and to orient the consumer to reality (Bulechek et al., 2008). In the presence of hallucinations, Townsend and Morgan (2018) also state that nurses must display an attitude of acceptance, helping the consumer share the content and context of the hallucination. It is important that a consumer understands that the voices they hear are unreal and are a part of the illness; distraction techniques, such as listening to music or watching Television (TV), can be used to direct the consumer towards reality (Townsend & Morgan, 2018).

As establishing and maintaining a therapeutic relationship is a basic part of the role of mental health nurses, managing delusions and hallucinations may be considered an extension of this, as noted by Pinho et al. (2017), therefore offering a reinforcement of any relationship with consumers. This relationship will grow as nurses build empathy and trust with a consumer, which should cause the consumer to begin to be critical of the false beliefs created by illness, allowing new intervention strategies to be implemented (Pinho et al., 2017).

What is unclear is how nurses working in mental health in KSA achieve these nursing practices and work with women who are experiencing symptoms of psychosis and psychotic illness. The preparation for nurses working in mental health in KSA is different to that in western countries such as the UK and Australia. It is not clear whether the level of educational preparation in mental health influences the understanding and practices of the

nurses. In addition, it is not clear whether the lack of advanced practice roles in mental health, such as those occupied by nurse practitioners, also influences the care of women with psychosis in KSA.

2.4 Conclusion

In this chapter, an introduction and explanation of the published paper included in this chapter were presented, followed by the paper itself; the latter provided a brief review of mental health nursing care for consumers with psychosis in KSA. An explanation was then offered in terms of how the paper contributes to this thesis. The paper reflected the very limited nature of studies in KSA related to the provision of nursing care to consumers with psychosis. This has created a significant gap in such research in KSA, which the current work seeks to redress.

It is essential to present a brief review of nursing care for consumers with psychosis in KSA, and this was included in this chapter. However, to provide a more comprehensive account of consumer experiences of psychosis and mental health nurses' perspectives on providing care to consumers with psychosis, a review of the relevant literature was required, and this is the premise of Chapters Three and Four. The reviews are presented as integrative reviews to offer unbiased and precise perspectives on the gaps in the literature which have formed the basis for the present research.

Chapter Three: Literature Review - Experiences of Psychosis and Recovery from Consumer Perspectives

3.1 Introduction

This chapter reviews the literature on consumers' experiences of psychosis and recovery. Based on the current research aim to explore the experiences of KSA women with psychosis, this chapter offers a broad overview of current qualitative research related to consumers with psychosis, therefore identifying the gaps in research to help understand how the present study can reduce these. The chapter is structured into three sections. The first section introduces the focus and rationale of the integrative review undertaken as a part of the background to this research study. The second section provides the text of a paper published in the *Journal of Psychiatric and Mental Health Nursing*, which reviews the published literature on mental health consumers' perspectives on their experiences of psychosis and recovery. Finally, the third section of the chapter offers a discussion of the key findings of the published paper in relation to the present research.

3.2 Background to the integrative review

The paper in the second section of this chapter is a published integrative review of qualitative literature from the last decade (2009-2020) on consumers' experiences with psychosis. The aim of this examination of the state of the literature was to highlight the knowledge gaps in this area and assist the understanding of how the research aim of exploring the experiences of KSA women with psychosis can add new insights and reduce the existing literature gaps. Undertaking this review in a global context and examining the reported experiences of consumers of all genders are seen as steps towards understanding the literature related to the

experiences of psychosis more broadly before focusing on the more specific context of KSA and pinpointing the experiences of women there.

3.3 The published paper

The following is the text of a paper published in the *Journal of Psychiatric and Mental Health Nursing* which reviews qualitative literature published in the previous decade in relation to mental health consumers' perspectives on their experiences of psychosis and recovery.

The Experience of Psychosis and Recovery from Consumers' Perspectives: An Integrative Review

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Declaration for Thesis Chapter Three

Declaration by candidate

In the case of paper entitled: The Experience of Psychosis and Recovery from Consumers' Perspectives: An Integrative Review, which appears in Chapter Three, the nature and extent of my contribution to the work was the following:

Nature contribution	Extent of contribution (%)
Concept development, research, original ideas, writing up.	70%

The following co-authors contributed to the work.

Name	Nature of contribution
Dr. Ian Munro	Draft review and editing.
Assoc. Prof. Cheryle Moss	Draft review and editing.

The following acknowledgement is made:

Professor Wendy Cross	For early contributions and ideas.
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The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

The experience of psychosis and recovery from consumers' perspectives: An integrative literature review

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Accessible summary

What is known on the subject?:

- Since the first decade of this century, few qualitative studies and literature reviews have reported consumers' experiences of psychosis and recovery. The findings from these studies need further exploration.

What does the paper add to existing knowledge?:

- New insights into consumers' experiences of psychosis were generated. Additionally, understanding of consumers' conceptions and experiences of recovery were reported. Consumers' insights into the enablers and barriers to recovery that they encountered were also identified. Gaps in the literature remain, particularly those related to the effects of gender and culture on consumers' experiences of and recovery from psychosis.

What are the implications for practice?:

- Nurses' understanding of consumers' perspectives and experiences of psychosis is vital to enhancing the quality of mental health nursing when caring for people living with psychosis.
- To support user-based recovery, mental health nurses need to incorporate person-centred approaches and reduce their preferencing of medical understandings of recovery.

Abstract

Introduction: Psychosis is a distressing disorder. Consumers' perspectives about their experiences of psychosis and recovery are essential aspects of mental health nursing.

Aims: To review contemporary evidence related to consumers' experiences of and recovery from psychosis.

Method: An integrative review was the method used; six databases were systematically searched. Of the 157 articles screened, 14 met the inclusion criteria and were assessed for quality using Joanna Briggs Institute Appraisal tools. Data were compared, classified and integrated.

Results: Findings revealed that consumers' experiences of psychosis included issues with self-expression and language, psychosocial problems and stigma. Also, consumers' experiences associated with their recovery were reported, and this included their perspectives on the enablers and barriers that they encountered.

Discussion: Consumer's experiences of and recovery from psychosis provide an essential basis for managing and working with people experiencing psychosis. Further research identifying the potential effects of gender and culture into consumers' lived experiences is required.

Implications for practice: Exploring the experience of someone with psychosis will help nurses to understand the impacts of this condition. This understanding can guide nurses to apply recovery-oriented practices. Specific aspects of psychosis experience, including gender and culture, should inform nurses' practices towards recovery.

KEYWORDS

consumer advocacy, culture, gender, mental health recovery, nursing role, psychosis

1 | INTRODUCTION

The experience of psychosis has the potential to be prolonged over multiple years and to significantly disrupt people's social, emotional, occupational and financial pathways through life (Morgan et al., 2012). These cumulative effects lead to considerations of psychosis as being among the most distressing mental disorders (Dominguez et al., 2011). The term *psychosis* refers to a group of conditions characterized by positive symptoms such as hallucinations, delusions and disorganized thoughts and behaviour, along with negative symptoms such as avolition, apathy, anhedonia and significant impairment in functioning (American Psychiatric Association, 2013). Psychosis causes an aberration from everyday perception and experience and can cause individuals to struggle with the reality (Leiviskä Deland et al., 2011). Historically, consumers with psychosis have faced bleak prospects with frequent hospitalizations and have difficulties in obtaining high-quality treatment and care (Iyer et al., 2015).

One author who reconstructed the notion of psychosis was Jung (1916). Jung (2009) maintained that the meaning of psychosis could be explored by the narrative of a person who lives that experience. Jung (2009) drew upon his own lived psychotic experience, to add to the scholarship through his *Red Book*. The *Red Book* recounted Jung's imaginative or psychotic experiences between 1913–1916 (Beebe, 2010).

The process of psychological recovery is commonly interpreted from two perspectives: service-based and user-based recovery. User-based recovery also can be called personal (Leamy et al., 2011) or person-centred (McKay et al., 2012) or consumer-centred recovery (Finnell et al., 2011). Schrank and Slade (2007) identified that *service-based* or clinical definitions of recovery stem from mental health service clinicians. Typically, clinical forms of recovery represent and involve an alleviation of symptoms. Clinical recovery can also be regarded as a medical model of recovery (Schrank & Slade, 2007). Additionally, Schrank and Slade (2007) refer to a *user-based* definition of recovery, developed from the self-help and consumer movement. Processes of personal evolution and progression are characteristic of user-based

recovery, and these are often intimately linked to consumers' actions to surmount adverse impacts that stem from psychosis (Slade et al., 2019). Schrank and Slade (2007) assert that a core feature of user-based recovery is that some symptoms might remain, despite consumers actively participating in and using treatments of their own choice.

Consumers with lived experiences of psychosis prefer and require a user-based recovery approach. User-based recovery involves the process of rebuilding a meaningful life in the context of living with a mental illness (Schrank & Slade, 2007). User-based recovery can be an effective way of understanding how people manage their lives after experiencing psychosis (Law & Morrison, 2014; McCarthy-Jones et al., 2013). With the rise of the mental health consumer movement, there is a greater focus on user-based recovery; thus, understanding of this is essential for contemporary mental health care (Nixon et al., 2010).

A research challenge over the past two decades has been to develop an evidence-base which simultaneously helps mental health professionals to support user-based recovery and respects the understanding that recovery is a unique and individual experience rather than something the mental health system does to a person (Leamy et al., 2011). In this case, recovery should be first understood from consumers' perspectives to inform the practice. So, health professionals need to find out what consumers experience, think and want, to be able to work with them and support their user-based recoveries. Consumers' voices can provide narration of the challenges of mental illness, in addition to hopes and dreams commensurate with recovery. These consumers' voices can test both health professionals and other people's awareness of mental illness, and this awareness may change the attitudes that stigmatize individuals with mental illness (Corrigan et al., 2010). Sunkel (2012) indicated that providing a voice to relatively voiceless individuals with mental illness can support and empower consumers to advocate for themselves. With empowerment, individuals can identify and address their needs and expose human rights violations, ultimately advancing their own lives and those of others (Sunkel, 2012). The involvement of individuals with mental health challenges generates a voice

that can advance and improve the development of policies, services, supports, evaluation and research (Farkas et al., 2005).

2 | BACKGROUND

Recovery from psychosis (user-based) has been examined in some qualitative studies (Nixon et al., 2010). Similarly, it has been identified that more research related to recovery from psychosis is needed (Van Eck et al., 2018).

User-based recovery psychosis research from a consumer movement perspective commenced early in the last century. For example, two classic texts are the United Kingdom-based Rachel Grant-Smith text *The Experience of an Asylum Patient* which calls for reform of neglect and abuse she had suffered (Montagu, 1922) and the United States-based Chamberlin's text *On Our Own: Patient Controlled Alternative to the Mental Health System* (1978). In Australia, Merinda Epstein, a well-known advocate for mental health argued the development of the Mental Health Council of Australia was a way of advancing consumers' voices to improve their mental health (Epstein, 2013).

Reviewing research evidence about consumers' perspectives of psychosis and recovery, since 2000, is essential to advance mental health nursing practice. Arguably, nurses understanding of psychosis from consumers' perspectives will inform and enhance the future of nursing care. In this section, a summation of crucial research evidence generated during the first decade of this century, related to consumers' experience of psychosis and recovery, is presented.

Jones et al. (2003) researched consumers' perspectives and experiences of hearing voices. The consumers reported the experience of hearing voices was frightening and harmful in their daily lives. Given these traumatic experiences, it is essential that professionals take an individual and holistic approach in care.

Andresen et al. (2003) reviewed qualitative literature about consumers' experiences of recovery from schizophrenia to create a conceptual model for recovery. The extracted and conceptualized meanings of recovery were identified as finding hope and purpose of life, re-establishment of identity and taking responsibility for recovery. Sells et al. (2004) conceptualized the meaning of recovering "the self" (p. 87) in consumers with schizophrenia, and they found that self-recovery was fostered through an understanding of how to build social distance with others. This social distance created clear life frames for consumers and helped them to reach self-recovery. Jarosinski (2008) explored the experience of hallucinations from consumers' perspectives of self and/or sense of being. The consumers in Jarosinski's (2008) study explored their identities of who they are with hallucinations and reported that hallucinations provided something positive in how consumers cared for and related to others.

From accounts of psychosis experience and recovery, Gee et al. (2003) proposed health-related quality of life domains associated with schizophrenia. The domains were represented as barriers

placed on relationships, reduced control of behaviours and actions, subjective experiences of schizophrenia, in addition to labelling and attitudes associated with stigma generated by others. The recovery elements reported in Gee et al.'s (2003) study included consumers' concerns with improving relationships and communication with families, besides appreciation of illness experiences.

The studies (Gee et al., 2003; Jones et al., 2003) generated significant knowledge about consumers' experiences of psychosis. These aspects include experiencing symptoms, struggling with relationships and experiencing stigma. These studies also investigated consumers' experiences of hallucinations and schizophrenia; however, a broader exploration of consumers' experiences with other psychosis disorders and symptoms is absent.

Components of user-based recovery for mental health in general are noted by Schrank and Slade (2007), while recovery from psychosis is reported in other studies (Andresen et al., 2003; Gee et al., 2003; Jarosinski, 2008; Sells et al., 2004). All of these studies reported that components of self-identity were important; many consumers expressed the need to have a *strong sense of self* in order to recover. Andresen et al.'s (2003) study identified that components of hope and meanings about the purpose of life were aspects of consumers' recovery. The importance of the component of connection and of joining the social life also was identified in studies by Gee et al. (2003) and Jarosinski (2008). These studies made significant contributions to the field of consumers' recovery in psychosis. However, further articulation of these and other meanings and components through the lens of consumers is needed. Moreover, the identification of enablers and barriers to user-based recovery are missed in these studies.

In the background above, the research findings related to the period 2000–2008 have been summarized. The following integrative review interrogates research and research evidence from 2009 onward. The purpose of this review is to locate and integrate contemporary qualitative evidence from consumers about their perspectives and experiences of psychosis and recovery. This integration will involve exploring whether issues and perspectives about consumers' experiences and recovery continue to be the same, whether more evidence has been added, or whether the evidence is changing and shifting.

3 | METHOD: INTEGRATIVE REVIEW

An integrative literature review was used as a methodology because there was limited evidence about consumers' experiences and recovery from psychosis (Whittemore & Knafl, 2005). Initial searching on the topic revealed that the available literature was too disparate to undertake a satisfactory scoping review or a systematic review of evidence.

This integrative review utilized qualitative studies, and qualitative literature and systematic reviews, the rationale for this was to assist in the conceptualization of consumers' experiences and recovery from psychosis. Methodologically, quantitative studies

were not considered because these approaches did not provide opportunities for data reporting the narrative voices of consumers. The methods of Whittemore and Knafl (2005) informed this integrative review for analysing and synthesising data derived from research. The integrative review method was based on a five-step process: problem identification, literature search, data evaluation, data analysis and presentation (Whittemore & Knafl, 2005).

3.1 | Problem identification

With the rise of the mental health consumer movement, there is a greater focus on user-based recovery, this understanding of user-based experiences and recovery from psychosis is essential for contemporary mental health care. The primary purpose of this review (2009 onwards) was to integrate the evidence from studies in which the perspectives of consumers reported on their lived experiences of psychosis and recovery. In keeping with this purpose, it was also essential to consider how the field of research and associated knowledge had evolved since the previous decade.

3.2 | Search strategy

3.2.1 | Inclusion criteria

The inclusion criteria for the integrative review were set. The articles must be about adult consumers and report their experiences of psychosis and/or recovery from psychosis disorders. The articles report primary qualitative research or qualitative findings from literature or systematic reviews. The articles should have been peer-reviewed and be published in English between 2009–2020.

3.2.2 | Exclusion criteria

The exclusion of articles was everything not fitting the inclusion criteria. Published research about the experience of complex mental health disorders in which psychosis was a co-morbidity or those that focused on the medical management of psychosis and recovery also were excluded. Quantitative studies were excluded because of having an insufficient emphasis on consumer voices and experiences. Grey literature was not included because of difficulties in judging the quality of the work, and having limited capacity to check for relevant data that might be incomplete, missing or absent (Hopewell et al., 2007).

3.2.3 | Database searching

Database searching was undertaken using keywords (MeSH headings combined with Boolean operators) as shown in Table 1. Six databases (AMED, CINAHL, Embase, Joanna Briggs Institute, Medline and PsycInfo) were searched using the search terms. A PRISMA

TABLE 1 Search terms for review

Consumer*	AND	Psychosis	AND	Experienc*
OR		OR Delusion*		OR Recover*
Patient*		OR Hallucinat*		
OR		OR Negative		
Client*		symptom*		
		OR Schizophrenia		
		OR Bipolar		
		OR Schizoaffective		
		OR Schizophreniform		

flow diagram (Figure 1) was used to report outcomes at different stages of the process from searching through to inclusion. Apart from identifying published articles from database searches, hand searching of reference lists of retrieved papers was also undertaken. This step was to identify relevant articles that may have missed through the database searching (Moher et al., 2009).

Initial database searching resulted in the identification of 11,222 papers, and an additional ten papers identified through manual searching. After duplicate citations were removed, a total of 9,224 relevant citations were screened. Titles and abstracts were reviewed manually based on the inclusion and exclusion criteria. Initial screening involved looking for a fit to the topic by examining titles; then, a second stage involved reviewing abstracts. These two steps left 157 papers for full-text review. The full-text review excluded 143, as they did not meet the inclusion criteria, which resulted in 14 articles being assessed for quality (See Figure 1). The omission of the term "user" in the search terms is a limitation of the review.

3.3 | Data evaluation (quality appraisal)

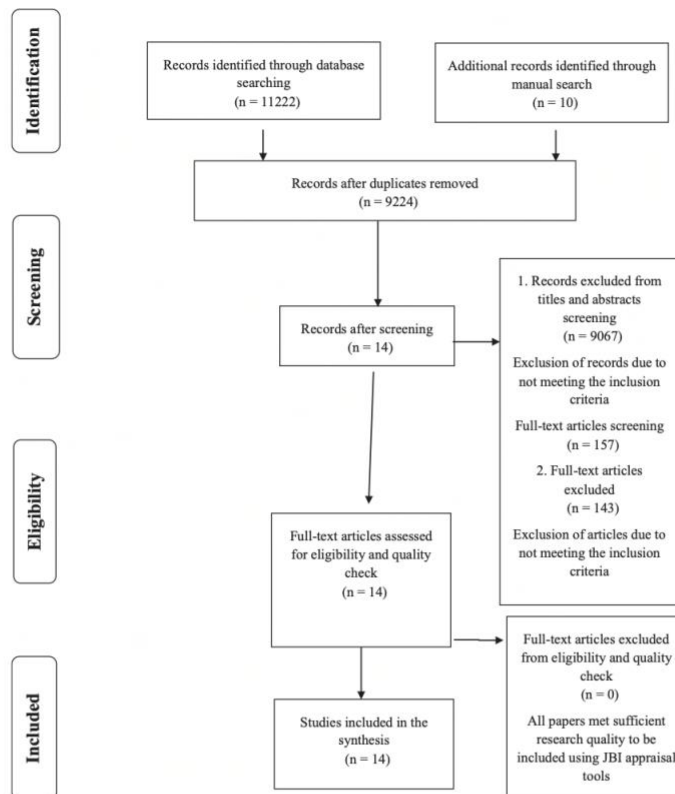
All 14 articles were assessed for scientific merit using the Joanna Briggs Institute (JBI, 2017) quality appraisal tools. To reduce the likelihood of bias, two investigators undertook each stage of the assessment process. All fourteen articles (11 primary studies; 3 reviews) were included in the integrative review, as they met the research quality criteria. A summary of the quality appraisal assessments is provided in Tables 2 and 3.

The qualitative studies included in the review (11 papers) were of very good to excellent quality, scoring seven to 10/10 on the JBI Qualitative Assessment and Review Instrument (JBI-QARI). The review papers (3) were assessed using the JBI Checklist for Systematic Review and Research Synthesis, with one systematic review scoring 11/11 and the other 7/11, while the meta-ethnography synthesis scored 8/11.

3.4 | Data analysis

After meeting the inclusion criteria and quality assessments, the data in the 14 articles were analysed according to Whittemore and Knafl's (2005) integrative review process. The initial categorization of the data was based on the aim of the integrative review. This step resulted

FIGURE 1 PRISMA flow diagram for article selection. The PRISMA flow diagram was informed by Moher et al. (2009)



in two main categories being created: (a) consumers' experiences of psychosis and (b) consumers' experiences of recovery from psychosis. Then, data reduction was applied; this involved extracting data from the included articles and coding it into a manageable framework.

The next step in data analysis was to identify subcategories within the framework. This step involved data comparison as an iterative process, by examining data clusters and the language of findings in the reported articles, all of which held constructions of consumers' experiences of psychosis and recovery from psychosis (Whittemore & Knafl, 2005). This process led to the identification of six subcategories related to the two main categories.

Two examples of labelling and constructing the subcategories from the texts follow. Example 1, the subcategory *struggling with self-expression and language* was constructed from the text: "there was a clear lack of speech and distancing from the symptoms during the descriptions" (Saavedra, 2009, p. 168). Example 2, the subcategory *the enablers and barriers for the recovery from psychosis* was constructed from the text: "support and its natural corollary, having to care for another" were "possibly the greatest contributors to the recovery" (de Wet et al., 2015, p. 29). A summary of the categories and subcategories is presented in Table 4.

Conclusion drawing and verification was the final phase of data analysis that moved the interpretive effort from the description of patterns and relationships to higher levels of abstraction, subsuming the particulars into the general (Whittemore & Knafl, 2005).

On completion of each subgroup analysis, a final step of data analysis in an integrative review was the synthesis of essential elements or conclusions of each subgroup into an integrated summation of the topic about the experience and recovery from psychosis with consumers' perspectives. Conceptualization of the primary sources integrated the subcategories into a comprehensive portrayal of the topic of consumers' experiences of psychosis and recovery from psychosis, thereby completing the review process.

4 | FINDINGS

4.1 | Participant characteristics

Across the fourteen papers, diagnostic classifications of participants were schizophrenia (five papers), psychosis (two papers), first-episode schizophrenia; first-episode psychosis; paranoid schizophrenia;

TABLE 2 Quality appraisal of the qualitative articles (JBI-QARI)

Question	Jenkins and Carpenter- Song (2009)	Mazor and Doron (2011)	Blakeman et al. (2013)	de Wet et al. (2015)	Henderson and Cock (2015)	Barut et al. (2016)	Nowak et al. (2017)	Kaar et al. (2019)	Leung et al. (2019)	Nxumalo Ngubane et al. (2019)
	Yes/No/Unclear/Not applicable	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the stated philosophical perspective and the research methodology?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the research question or objectives?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the methods used to collect data?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the representation and analysis of data?	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the interpretation of results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there a statement locating the researcher culturally or theoretically?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Is the influence of the researcher on the research, and vice versa, addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Are participants, and their voices, adequately represented?	No	No	Unclear	Yes	Yes	Unclear	Unclear	No	Yes	Unclear
Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	Unclear	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes
Do the conclusions draw in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Score	8/10	9/10	8/10	9/10	10/10	7/10	9/10	9/10	10/10	9/10
Overall appraisal	Include	Include	Include	Include	Include	Include	Include	Include	Include	Include

schizophrenia-related disorders; hearing voices; chronic schizophrenia-related disorders; and chronic psychotic illnesses. In Table 5, the 14 included studies are summarized in terms of their research designs, aims and key findings.

The eleven primary studies were conducted in different countries. In the United States of America, there were three articles (Barut et al., 2016; Blakeman et al., 2013; Jenkins & Carpenter-Song, 2009), followed by two in each of the United Kingdom (Kaar et al., 2019; Leung et al., 2019) and South Africa (Nxumalo Ngubane et al., 2019; de Wet et al., 2015), then one study in each country: Australia (Henderson & Cock, 2015), Poland (Nowak et al., 2017), Israel (Mazor & Doron, 2011) and Spain (Saavedra, 2009).

In nine of the studies, the majority of participants were male, such as in the study of Barut et al. (2016), males numbered 13 and females seven. Also, in Saavedra's (2009) study, the ratio difference between both genders was high, males were eight and females were only two. One qualitative study had a female-only focus (Nxumalo Ngubane et al., 2019). One meta-ethnographic synthesis study (Holt & Tickle, 2014) had a slight female majority (52%). de Wet et al. (2015) failed to report gender. Most participants in these studies were aged 18–64 years which is within the adulthood stage, given young adulthood is where the emergence of schizophrenia and other psychotic disorders has been identified (American Psychiatric Association, 2013). Two studies (Holt & Tickle, 2014; Nxumalo Ngubane et al., 2019) had participants aged over 65 years. Participants in the studies were recruited using different approaches; for example, purposeful sampling, advertisements and flyers. The settings for research studies were different; some used hospital inpatient wards, others used community settings, out-patient clinics, day centres and care homes. Socio-demographic characteristics often were reported related to the educational level, living arrangements, marital and the employment status of participants.

4.2 | The overall categorization of findings

Categories were extracted using a deductive approach, so categories were created and then searched to be validated in the articles (Snieder, 2009). The two derived categories were "consumers' experiences of psychosis" and "recovery from psychosis from consumers' perspectives." The first named category included four subcategories, while the second named category contained two subcategories. The data analysis and integration took into consideration the differences in study designs, settings, populations and assessment tools.

5 | SYNTHESIS OF FINDINGS

5.1 | Consumers' experiences of psychosis

The first category of findings confirmed a range of consumers' experiences of psychosis about symptoms and their effects on

consumers' lives. Four subcategories were identified: experiencing psychosis symptoms, experiencing the impact of psychosis on social relationships, struggling with self-expression and language, and the impact of stigma in daily life.

5.1.1 | Experiencing psychosis symptoms

The first subcategory highlighted what consumers reported about experiencing symptoms that accompanied psychosis. Consumers experienced at least one of the following symptoms: hallucinations, delusions, disorientation and/or loss of a sense of self. Hallucinations were a common experience, which consumers described as distressing, frightening, confusing and exhausting (Holt & Tickle, 2014; Walsh et al., 2016). The voices frequently interrupted the consumers' speech; and the nature of the voices was reported as disrupting of the consumers' daily lives (Saavedra, 2009). The auditory hallucinations reported by Nxumalo Ngubane et al. (2019) did not cause distress for the participant who talked about this experience because the participant rejoiced in hearing the voice of a beloved one.

Experiencing delusional thoughts was distressing to the point where the delusions forced consumers to do "bad things," these were represented by committing offences, as a consequence of believing that they had supernatural powers (Saavedra, 2009, p. 172). When hallucinations and delusions were combined, they left some consumers questioning reality. Some consumers reported finding symptoms overwhelming to the point that they experienced a loss sense of self (Walsh et al., 2016).

5.1.2 | Experiencing the impact of psychosis on social relationships

The second subcategory was the result of clustered data, where participants had identified the impact of psychosis on their social relationships. For example, participants reported impacts on personal relationships and psychosocial problems, the experience of psychosis impacting on relationships in general, experiencing deterioration in social contacts and finding it challenging to establish new relationships. The extent of psychosocial problems with psychosis was clear, such as the loss of control with impulsivity that disrupted the consumers' lives (Henderson & Cock, 2015). Jenkins and Carpenter-Song (2009) identified schizophrenia-related disorders and stigma impacted social relationships.

Additionally, Walsh et al. (2016) reported in a systematic review that consumers with schizophrenia experienced many impacts on their relationships, including deterioration in existing relationships and difficulties in creating new relationships. They also found this was in part due to experiences of stigma and discrimination. The experiences of psychosis could render consumers to experience extreme difficulties in communication. Blakeman et al. (2013) reported upon a poster-sized piece of embroidery work of one consumer with schizophrenia who rarely spoke. The

	Hitch et al. (2013)	Holt and Tickle (2014)	Walsh et al. (2016)
Question	Yes/No/Unclear/Not applicable		
Is the review question clearly and explicitly stated?	Yes	Unclear	Unclear
Were the inclusion criteria appropriate for the review question?	Yes	Yes	Yes
Was the search strategy appropriate?	Yes	Yes	Yes
Were the sources and resources used to search for studies adequate?	Yes	Yes	Yes
Were the criteria for appraising studies appropriate?	Yes	Yes	Unclear
Was critical appraisal conducted by two or more reviewers independently?	Yes	Unclear	Yes
Were there methods to minimise errors in data extraction?	Yes	Unclear	Unclear
Were the methods used to combine studies appropriate?	Yes	No	Yes
Was the likelihood of publication bias assessed?	Yes	Yes	Yes
Were recommendations for policy and/or practice supported by the reported data?	Yes	Yes	Yes
Were the specific directives for new research appropriate?	Yes	Yes	Unclear
Score	11/11	8/11	7/10
Overall appraisal	Include	Include	Include

TABLE 3 Quality appraisal of the systematic and literature review studies**TABLE 4** Findings: Categories and subcategories

Categories	Subcategories
Consumers' experiences of psychosis	Experiencing psychosis symptoms Experiencing the impact of psychosis on social relationships Struggling with self-expression and language The impact of stigma in daily life
Recovery from psychosis from consumers' perspectives	The meaning of user-based recovery from psychosis The enablers and barriers for this recovery

consumer embroidered about her daily experience of illness. Through content analysis, insight into her relationships with other people was provided. She was able to indicate her relationships with others and how these relationships were important to her, to the extent of creating a lasting embroidery. The review by Holt and Tickle (2014) identified consumers' experiences of the power that hearing voices wielded over the hearers and how this impacted on their relationships with others. For example, Fenekou and Georgaca (2010) reported that one voice hearer said: "We were sitting there...people, having a cup of coffee and the voice told me to get up and leave the table... you have nothing to do with these people...and I do not want to ever see you with them again"

(p. 137). Saavedra (2009) identified that for some consumers, the effect of schizophrenia on their personal relationships within homecare had been dominated by loss, loneliness and abandonment. Saavedra (2009) argued that some experiences could be defined as traumatic because of the impact of illness on consumers' social connections.

Regarding the need to be connected with others, Barut et al. (2016) examined the meaning of belonging and hope in consumers with chronic schizophrenia-spectrum disorders and found participants frequently felt like outsiders and experienced loneliness and isolation from the community. Nxumalo Ngubane et al.'s (2019) study reported that family, community, traditional healers and health professionals often took a paternalistic stance of knowing what is best for consumers and intervened accordingly. These patterns of relationships were reported as being painful, as the consumers indicated they were not being listened to and understood.

5.1.3 | Struggling with self-expression and language

The third subcategory reflected a cluster of data that revealed consumers' struggles with self-expression and with communication due to their experiences of psychosis. These were reported in two studies. One study (Blakeman et al., 2013) was reported through the embroidery work of a consumer who was silent. The study revealed

TABLE 5 Key findings of the included articles

Author	Design	Participants number	Data collection method	Data analysis method	Aim	Key findings
Jenkins and Carpenter-Song (2009)	Qualitative, using grounded theory	90	Anthropological semi-structured interviews	Thematic categories inductively derived	To investigate the subjective experience of the stigma attached to schizophrenia-related disorders.	Understanding of stigma experience related to psychosis identified by 2 aspects: - Social relations: Which includes anonymous social interactions, work, dating, family, acquaintance and friendship relations. - Identity domains: In medication use, popular culture, gender, self-presentation, social class and ethnicity.
Saavedra (2009)	Qualitative	10	Narrative interviews	Social positioning analysis	To explore qualitative changes in the life narratives of persons diagnosed with paranoid schizophrenia who were receiving recovery treatment in special care homes.	1. Personal relationships experienced with psychosis: Long-stay consumers create their identities by using more categories related to relationships and make fewer references to illness than short-stay consumers. 2. Experience of illness: - Long-stay consumers make fewer delusive or hallucinatory utterances, and their narratives have more elements that can be shared in the community. - Long-stay consumers show significant language resources and greater capacity for agency.
Mazor and Doron (2011)	Qualitative phenomenological approach	15	In-depth interviews	1. Connection stage 2. Process of open coding 3. Connections established among meta-themes	To understand and explore the meaning of rehabilitation and return to the community under the new legislative setting, from the viewpoint and experiences of the participants experienced schizophrenia.	The continuous flow of recovery appeared in the experience of the participants with psychosis through the following: - Viewing institutionalization as transforming everyday life to an abnormal stage. This stage started with exposure to the illness and led to the hospitalization. - Viewing institutionalization as a process moving from the abnormal back to the normal with handling the illness. - Viewing the return to the community as re-birth. - Viewing community-based rehabilitation as reality, which enables normality alongside mental illness.
Blakeman et al. (2013)	Qualitative	1	Embroidery work of consumer with schizophrenia	Content analysis	To provide insight into consumer lived experience of schizophrenia through content analysis, show how human experience can be expressed in unexpected ways, and expand the understanding of interpersonal communication and milieu management.	The consumer embroidered her experience of psychosis. This represented the following experiences, specifically love (12.14%), followed by other people (11.95%), song lyrics (9.20%), self (5.98%), emotions: other (5.29%), food and drink (4.14%), outside places (4.41%), possible symptoms of illness (3.22%), conversation (3.22%) and religion (2.30%).

(Continues)

TABLE 5 (Continued)

Author	Design	Participants number	Data collection method	Aim	Key findings
Hitch et al. (2013)	Systematic review	9 studies (encompassing 73 participants)	A systematic search for literature	To answer the question of how people who have experienced psychosis describe their engagement in activities of daily living and occupations?	Four overarching themes about psychosis experience identified: 1. My emotions & identity. 2. My health & well-being. 3. My relationship with family, friends & community. 4. My activities & occupation.
Holt and Tickle (2014)	Literature review	7 papers with 139 participants	A systematic search for literature	To identify, appraise, and synthesize the current peer-reviewed qualitative literature which explores the phenomenon of hearing voices from a first-person perspective.	Five critical themes about the experience of hearing voices: 1. Identity of the voices. 2. Power of the voices wielded over the hearer. 3. Impact of hearing voices on relationships. 4. Relationship with voices. 5. The distinction between thoughts and voices.
de Wet et al. (2015)	Qualitative, using a phenomenological approach.	7	Interviews	To investigate how a small group of participants experienced their recovery from the first episode in schizophrenia.	- Factors associated with participants' experience of recovery from psychosis: support, spirituality, stigma, the importance of participants' positive attitude and their belief in their abilities. - The meaning of recovery from psychosis through their experiences: doing things again like before illness and independence from others.
Henderson and Cock (2015)	Qualitative	10	Interviews	To describe and explain the responses of young people to their first episode of psychosis.	- The fundamental psychosocial problem experienced by participants with psychosis was the loss of control that resulted in disruptive lives. - The core variable in psychosis experience was harnessing resilience, which was accounted for most of the variance in their behaviour to overcome that problem.
Barut et al. (2016)	Qualitative	20	Semi-structured interviews	To explore the meaning of sense of belonging and hope in the lived experiences of persons with chronic schizophrenia-spectrum disorders receiving acute inpatient treatment.	- Senses of belonging and hope were both identified as valuable or even vital in the psychosis experience. - Senses of not belonging and/or feeling hopeless were prevalent experiences in psychosis. - Participants with psychosis frequently felt like an outsider and experienced loneliness and isolation.

(Continues)

TABLE 5 (Continued)

Author	Design	Participants number	Data collection method	Data analysis method	Aim	Key findings
Walsh et al. (2016)	Systematic review	A total of 27 studies with 408 participants.	A systematic search of the literature	Qualitative meta-synthesis	To determine the themes that can be identified across the qualitative studies about the personal experience of having schizophrenia.	Significant themes identified as part of the experience of schizophrenia were: 1. The experience of symptoms including hallucinations, disorientation & loss of sense of self. 2. The process of acceptance through shame & loss, regaining a sense of self, acceptance & reengagement. 3. The personal relationship with the deterioration of existing relationships, difficulty establishing new relationships, stigma and discrimination & the importance of social support in coping. 4. Treatment experiences including interaction with providers and medications 5. Spiritual practices & faith.
Nowak et al. (2017)	Qualitative	28	Focus group interview	Inductive thematic analysis approach	To explore definitions of recovery among Polish consumers with lived experience of schizophrenia and hear their recommendations regarding elements that should be considered in the planning of a recovery-oriented psychosocial intervention.	- The main themes of user-based recovery from schizophrenia experience are psychological recovery, relationships with others, wellness strategies, clinical understanding of recovery and support systems. - Consumers recommended the element of recovery-oriented intervention be based on their experience of schizophrenia. These recommendations were that interventions should be flexible, individualized and facilitative of personal growth.
Kaar et al. (2019)	A qualitative study	20	Focus groups	An inductive approach	To explore mental health consumers' experiences of anti-psychotic medication decision-making to develop a consumer decision aid to promote shared decision-making.	The themes of the analysis based on the consumers' experience of taking medications emerged to: - Adverse effects. - Mode and time of administration. - Symptom control. - Autonomy.
Leung et al. (2019)	Qualitative	8	Semi-structured interviews	Thematic analysis	To examine Cognitive Bias Modification for paranoia (CBM-pa) for acceptability in consumers with psychosis.	Thematic analysis of consumers' experiences with the programme yielded five overarching themes: - Engagement. - Programme understanding. - Challenges and enablers. - Perceived impact of CBM-pa. - Application of CBM-pa.
Nxumalo Ngubane et al. (2019)	Qualitative	15	Semi-structured interviews	Interpretive phenomenological analysis	To explore the experiences and meanings of recovery for Swazi women living with schizophrenia.	Four superordinate themes about the experience of recovery from schizophrenia were identified: - The emotionality of illness of the brain. - Pain! Living with the illness and with others. - She is mad, just ignore her. - Being better.

that silence should not be inferred to be detachment; it was just that this consumer communicated in a non-traditional way (Blakeman et al., 2013). So, the embroidery can be considered an example of an Augmentative and Alternative Communication (AAC) strategy that facilitates communication with consumers with complex communication needs (Hemsley & Balandin, 2004). Although the consumer did not often communicate verbally, she was able to express her thoughts and feelings through the embroidery (Blakeman et al., 2013). The second study by Saavedra (2009) found that consumers with schizophrenia in care homes have difficulties in expressing their symptoms to others. These difficulties observed were mainly due to psychotic symptoms such as hearing voices, which in turn would create interruptions in the consumers' speech and expression (Saavedra, 2009).

5.1.4 | The impact of stigma in daily life

The fourth subcategory identified from the data was the experience of the stigma associated with psychosis and how it influences social relationships in different situations within consumers' lives. Jenkins and Carpenter-Song (2009) investigated consumers' subjective experiences of the stigma attached to schizophrenia-related disorders. In particular, Jenkins and Carpenter-Song (2009) examined the inter-relationships between gender and ethnicity. These researchers found that more women than men reported stigma and that the non-dominant ethnic groups often pathologized. Stigma was also more strongly identified when social issues such as low finances, lack of housing options or relying on government benefits were present. Taking medications, especially anti-psychotic medications, exposed consumers to stigma because of the presence of side effects. Stigma related to medication also occurred because other people witnessed consumers taking medication, thus exposing them as somebody who is ill. Additionally, the side effects of the medication could result in consumers being overweight, which in turn further contributed to consumers' experiences of stigma. Finally, the authors found that stigma impacted upon the relationships of consumers (Jenkins & Carpenter-Song, 2009).

Walsh et al. (2016) reviewed the influence of stigma on consumers' personal lives. This influence of stigma came from being diagnosed and having symptoms of psychosis, which consumers reported as leading to alienation from their families, friends and their communities. Nxumalo Ngubane et al.'s (2019) study explored stigma experienced by Swazi women with schizophrenia; these women suffered by being labelled as "mad" (p. 156) by the community. Also, they experienced ignorance and rejection by the family, and further segregation by society. These stigma experiences indicated others also tarnished women consumers. The consumers experienced discrimination in their workplaces, mostly when they wanted to return to work, and employers often were not accepting of them. These women also reported that they experienced nurses and doctors' prejudices towards their illnesses.

They also reported the negative impact that frequent seclusions had on their experiences of illness; all of which increased their experiences of the internal stigma associated with having a mental illness.

The data from the eight studies informed findings regarding the level of distress and other various experiences that consumers can have when living with psychosis. In the next section, studies that described aspects of consumer recovery are discussed and synthesized.

5.2 | Recovery from psychosis from consumers' perspectives

Eleven papers generated evidence related to the second category "consumers' experiences of recovery from psychosis.". From this evidence, two subcategories were generated. The first subcategory highlighted consumer insights into the meaning of user-based recovery from psychosis; the second highlighted what consumers considered as the enablers and barriers for this recovery.

5.2.1 | The meaning of recovery from psychosis

Review of the extracted data exposed that consumers attached multiple meanings to recovery from psychosis. Recovery for these consumers involved changes in social connections and relationships, acceptance of their illnesses, faith in and re-establishment of self, working with the management of symptoms, moving into meaningful working activities, taking empowerment and finding the courage to go beyond limits. All of these findings represented the meanings that user-based recovery held for consumers (Schrank & Slade, 2007). A study by Mazor and Doron (2011) combined both user-based recovery and service-based recovery perspectives. Consumers in this study expressed the user-based recovery meanings associated with having a purpose in life, responsibility and control over their own lives, connection with the community, coping with life and illness management strategies, and knowing available services. Other consumers viewed their recovery as "being out" and not dependent on hospital and treatment for a long time; this was interpreted as reflecting service-based recovery perspectives (Mazor & Doron, 2011).

Meanings of user-based recovery were reflected in a study by Nowak et al. (2017), who identified that consumers sought recovery through improved relationships with others. In addition to understanding the available support systems and services, consumers in de Wet et al. (2015) generated the meaning of recovery as being able to do things again, as before illness and finding independence from the voice-hearers' perspectives. Mazor and Doron (2011) suggested that the meaning of recovery from community-based rehabilitation for participants experiencing schizophrenia started with the first steps in hospital, to returning to the community and starting "community-based rehabilitation" (p.

351), which emphasized that recovery was possible from mental illness. Walsh et al. (2016) discussed the personal experience of living with schizophrenia, including the meaning of recovery and finding that recovery illustrated a process of acceptance of the disorder with aspects of shame and loss, regaining a sense of self, acceptance and reengagement. Moreover, recovery was identified through the treatment experiences, which included interaction with providers and medications.

Hitch et al. (2013) found that consumers discussed recovery through the lens of their engagements in activities of daily living and occupation. Hitch et al. (2013) argued that consumers identified engagement and maintenance of a profession or an occupation as being essential to a successful recovery from psychosis. This recovery through professional work suggests that it assists consumers to maintain social connections and that work is a source of meaning and usefulness in consumers' lives. Nxumalo Ngubane et al. (2019) identified that women with schizophrenia believed that recovery from the "illness of the brain" (p. 156) was possible and acknowledged that recovery was an individually unique process. This process was started by the strong faith in self to recover, and in being persistent in wanting to go beyond the limits of the illness to become the best, for themselves and for their significant others.

5.2.2 | The enablers and barriers for the recovery from psychosis

Data in this integrative review revealed that consumers viewed enablers and barriers as essential factors in their recovery experiences. de Wet et al. (2015) reported the most frequent recovery enabler was the support that came from either professionals or social contacts; these were "possibly the greatest contributors to the recovery" (p. 29). Additionally, de Wet et al. (2015) indicated that when consumers received support in specific environments; this contributed to their sense of agency in the world and supported them in believing in their own abilities.

Spirituality and faith were viewed as enablers for recovery in three studies (Nxumalo Ngubane et al., 2019; Walsh et al., 2016; de Wet et al., 2015). Prayer can be more vital in helping consumers recover than prescribed medication (de Wet et al., 2015). Faith and spirituality were coping mechanisms that helped consumers transcend their daily challenges (Walsh et al., 2016). Nxumalo Ngubane et al. (2019) found that religion and faith contributed to consumers' recoveries. Activities such as joining a Christian church in the community or attending prayer meetings with other members of the church could make a difference. This gathering with the community also helped consumers to engage with social connections that supported their recovery.

The studies of de Wet et al. (2015) and Henderson and Cock (2015) identified the need for a positive attitude towards recovery as a significant enabler with a focus on resilience. Within Henderson and Cock's (2015) study, consumers showed how resilience contributed to recovery, as this resilience overcame the loss of control that

was often accompanied by psychosis. Consumers' positive attitudes were explored by Barut et al. (2016), and these were found to contribute to a sense of belonging and hope; these experiences were identified as valuable and vital for recovery in chronic schizophrenia-spectrum disorders.

Nxumalo Ngubane et al.'s (2019) study highlighted that consumers' "faith in self" and believing that they were best placed to know when they had recovered were enablers for recovery. Health professionals were acknowledged for their part in the women's recovery by spending time with them, talking with them, encouraging them to be involved in hospital activities and giving medication on time. The regular support from family, emotionally and financially, was essential for consumers; this support increased their motivations to overcome their illnesses. The community saw these women as being socially useful, wanted, accepted, included, needed and valued, all of which were essential to recovery.

The engagement of consumers in shared decisions about medication was an enabler to recovery, as this helped consumers to gain symptom control and enhanced the autonomy of consumers (Kaar et al., 2019). Consumers' engagement in therapeutic interventions was identified as improving their emotional well-being and recovery (Leung et al., 2019).

Barriers to consumers recovering from psychosis were identified in many studies as being linked with stigma. The studies of de Wet et al. (2015), Jenkins and Carpenter-Song (2009) identified stigma, in the form of self-stigmatization or discrimination. This stigma was viewed as being a significant barrier to consumer recovery from psychosis. Barut et al.'s (2016) study found that consumers' experiences of not belonging and feelings of hopelessness as a result of stigma were detrimental. These experiences were prevalent among consumers with chronic schizophrenia-spectrum disorders. As a consequence of these barriers, consumers reported frequently feeling like outsiders and experiencing loneliness and isolation. Experiences such as these lead to difficult recovery due to negative impacts on consumers' emotional states.

Finally, Nxumalo Ngubane et al. (2019) indicated that social stigma from family and community towards consumers with schizophrenia hindered their recovery. Additionally, prejudices from professional staff towards consumers with mental illness acted as a barrier to recovery, and seclusion experiences in hospital increased feelings of stigma and shame, which also created impediments to recovery.

6 | DISCUSSION

Findings from the articles reporting consumers' experiences of psychosis symptoms (Barut et al., 2016; Blakeman et al., 2013; Henderson & Cock, 2015; Holt & Tickle, 2014; Jenkins & Carpenter-Song, 2009; Nxumalo Ngubane et al., 2019; Saavedra, 2009; Walsh et al., 2016) were mainly consistent with non-consumer or medical-based literature about psychosis (American Psychiatric Association, 2013; Haddock et al., 1999; Heckers et al., 2013; Parker, 2014; Parnas &

Henriksen, 2014; Strauss, 1989; Tandon et al., 2009; World Health Organization, 2018). In the medical literature, there is a sense of how psychosis is understood and managed, but this integrative review enriches the field about how consumers live with distressing symptoms of psychosis. For example, although hallucinations are considered as disturbing symptoms in the medical-based literature, in Nxumalo Ngubane et al.'s (2019) study, one of the consumers was not distressed by hallucinations.

The reviewed studies reported the impact of psychotic symptoms on developing appropriate social connections and deterioration in interpersonal communications and relationships. This decline of relationships could accompany problems in self-expression and stigma. Psychosis can have a devastating effect on consumers' relationships. For example, Redmond et al. (2010) reported that young people experienced impoverished intimate and loving relationships. The studies (Barut et al., 2016; Blakeman et al., 2013; Henderson & Cock, 2015; Holt & Tickle, 2014; Jenkins & Carpenter-Song, 2009; Nxumalo Ngubane et al., 2019; Saavedra, 2009; Walsh et al., 2016; de Wet et al., 2015) reported relationship deterioration as a significant impact of the psychosis experience; they also reported improving relationships as the main component of psychosis recovery. User-based recovery revealed that relationships are essential to improve the quality of life (Thomas et al., 2016). Reduced personal self-expression and conversations were identified as being associated with the loss of social relationships (Macdonald et al., 2005). The review found stigma, as a consequence of psychosis was a barrier in consumers' social activities and relationships and a significant barrier to recovery. These findings were aligned with Stain et al. (2012) and Chan et al. (2016).

In the background of this integrative review, two studies (Gee et al., 2003; Jones et al., 2003) explored consumers' experiences with schizophrenia and hallucinations. These studies addressed the aspect of psychosis related to experiencing symptoms, the impacts on relationships and stigma. This integrative review extends the previous findings and identified new perspectives about consumers' struggles with self-expression and language, and issues associated with first-episode psychosis (Henderson & Cock, 2015; de Wet et al., 2015).

The integrative review findings have illuminated different aspects of user-based recovery in psychosis (Schrack & Slade, 2007). Faith can be an essential factor to impact recovery. Virdee et al. (2016) and Posmontier and Fisher (2014) argued about the impact of faith on recovery for some consumers can be more significant than that of medication.

Experience and recovery from psychosis as discussed earlier in the background (research between 2000–2008) revealed four studies (Andresen et al., 2003; Gee et al., 2003; Jarosinski, 2008; Sells et al., 2004) in which the meaning of recovery was conceptualized. Consumer's discourses assisted these conceptualizations of user-based recovery. Conceptualizations as reported by Schrack and Slade (2007) included having hope, a purpose of life, connection and self-identity. The findings from the current integrative review

enrich the meaning of user-based recovery through the lens of consumers having the purpose of life and self-identity. The newly added conceptualizations of recovery in this review fall under the lens of consumer empowerment. Additionally, newly emerged insight into the enablers and barriers to recovery from psychosis that consumers experienced has been reported. The enablers involved support of health professionals and others, positive attitudes towards having illness experiences and experiencing hope and faith. Stigma and discrimination by others were identified by consumers as barriers to recovery.

Another significant finding of this integrative review was the reporting of culture and gender in relation to women who have psychosis and to their recovery. For instance, Nxumalo Ngubane et al. (2019) advances knowledge about what is it like to be a woman from unique culture and to experience psychosis.

The findings of this integrative review generate essential insights into the experiences of consumers with psychosis, which in turn provide a basis for further development of clinical practice in mental health nursing. Mental health nurses should use user-based recovery-oriented practices where they focus on the person with mental health problems, rather than focusing on symptom reduction. A significant finding of this review was about the impact of psychosis upon relationships, so nurses must work with consumers' insights and hopes as they seek to improve their relationships and achieve recovery. Nurses need to work with consumers to reduce felt stigma and to support consumers' self-expression and communication skills. In principle, nurses' working with consumers' insights will support user-based care and become a cornerstone in their recovery.

Nursing education needs to draw upon consumers' lived experiences of psychosis and recovery in order to promote experiential understandings in the nursing workforce. This knowledge should consider the unique perspectives of each consumer that is related to culture and gender.

It is crucial to enrich mental health nursing research with an understanding of the lived experiences of psychosis and recovery; this will advance future nursing interventions. Also, it is essential to advance nursing research in areas of culture and gender in the context of psychosis and recovery.

7 | CONCLUSION

All studies explored consumers' perspectives and reported on their experiences of psychosis and/or recovery. This review highlights categorical findings related to psychosis in the daily lives of consumers, including social relationships, self-expression and communication difficulties and stigma. The categorical finding of user-based recovery involved health professionals and others, highlighting the essential need for positive attitudes and experiencing hope and/or faith to enhance recovery. Nurses need to be aware of barriers to recovery identified by consumers especially related to stigma and seek to reduce the impacts of on their lives and in care. There is a need for nurses to adopt user-based recovery-oriented care practices and

principles that are informed by these findings, which include gender and culture. Nursing education to promote experiential understanding of psychosis should be user-based and informed by consumers.

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CONFLICT OF INTEREST

None.

ETHICAL APPROVAL

As an integrative review, the ethical review was not required for this study.

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3.4 Discussion of key findings in the published paper in relation to the present research

The paper presented above (Alyahya, Munro, & Moss, 2022), addresses both consumers' experiences of psychosis and their perspectives on recovery. The category of consumers' perspectives on recovery was identified based on several studies which emphasised recovery as part of the overall experience of psychosis. Most such perspectives reflect a user-based approach, making it potentially worthwhile to briefly highlight in the following sub-section the user-based recovery approach to psychotic experiences and to establish a link between this approach and the aim of the present research.

The other sub-section discussed from an insight emerging from the integrative review, which was the existence of one study which focused on women's experiences of psychosis in a specific cultural context. An examination of the women's experiences of psychosis explored in that study might have implications which could inform the exploration of KSA women's experiences of psychosis in the current research.

3.4.1 User-based recovery from psychosis

Two main approaches to recovery from mental illness were identified by Schrank and Slade (2007): service-based and user-based. Consumers' recovery experiences in the reviewed studies from the last decade in Alyahya et al. (2022) reflected these two approaches. The consumers' views emerging from the reviewed studies also revealed the dominance of service-based recovery has decreased over time, and there is a corresponding tendency to understand recovery from a user-based perspective. The consumers' perspectives in one study (de Wet et al., 2015) also confirm the notion that user-based recovery from psychosis is both unique to each individual and a continuous experience rather than a final endpoint.

In the current research's exploration of KSA women's experiences of psychosis, understanding how they view and experience recovery as part of their experience of psychosis is presented from their perspectives. Their experiences of receiving care from nurses may also reveal the recovery approaches adopted in mental health nursing in KSA at present. Therefore, this research may provide new insights into recovery from psychosis in this specific context.

In the context of KSA, no previous studies to date have reported on consumers' experiences of psychosis. This leads to a limited understanding of how consumers view their recovery as part of their psychotic experiences, including whether service-based or user-based recovery approaches are adopted by nurses providing care to women. This lack of studies also reveals an important gap in mental health research in KSA which will be reduced by the present research.

3.4.2 Gender and cultural effects on psychosis

The influences of gender and culture on the experiences of women living with psychosis in KSA are important to this research. The above integrative review included one study (Nxumalo Ngubane, McAndrew, & Collier, 2019) which focused on perspectives of gender and culture within psychosis and explored what is it like to be a woman with schizophrenia from a unique culture (Swaziland). This study offered significant information to the key findings of the integrative review, as the women participants revealed the impact of psychosis on their relationships with others, the social stigma they experienced, and the consequences of such stigma for their recovery. The women also highlighted their understanding of recovery and what helped or hindered their recovery in the Swazi cultural context.

The perspectives of Swazi women in Nxumalo Ngubane et al. (2019) regarding relationships, social stigma, and recovery may inform the interpretation of KSA women with psychosis in

this research. The many shared norms in the two cultures may give insights about being a woman with psychosis in a community which follows strict cultural and religious traditions. The study of Nxumalo Ngubane et al. (2019) is a crucial addition to the literature; further studies are needed to explore experiences of psychosis of women from different cultures. It is hoped that the present research will add more insights and decrease the gap in gender-and culture-related studies from the perspective of women's experiences of psychosis in KSA's cultural context.

3.5 Conclusion

This chapter included a published integrative review of the latest qualitative literature on psychotic experiences and recovery from consumers' perspectives. The text of this paper was then presented, followed by a commentary on some of the key findings of the paper related to the present study. Consumer experiences, as derived from the integrative review, centred on two categories: consumers' experiences of psychosis and consumers' perspectives on recovery from psychosis. Experiencing recovery from psychosis was identified as an essential aspect of the psychotic experience in this review. The present research focuses on women's experiences of psychosis, which may include recovery as part of their psychotic experiences; this might be examined as part of analysing their accounts. Moreover, as only one study identified in the integrative review featured women's experiences within a particular culture, a gap in the literature on women and culture-related studies of psychosis remains. The present research will in part address this gap by adding to existing knowledge of KSA women's experiences of psychosis and recovery.

Exploring nurses' current practices and experiences in mental health nursing care for KSA women with psychosis is another aim of the present study. The next chapter reviews the latest

literature on nurses' understandings of and interventions for consumers with psychosis to identify the gaps in the literature in this area which may inform the present study.

Chapter Four: A Literature Review of Qualitative Research on Mental Health Nurses' Experiences of and Interventions for Consumers with Psychosis

4.1 Introduction

This chapter reviews qualitative research in the last decade (2009-2020) on mental health nurses' experiences of and interventions for consumers with psychosis. One aim of this thesis is to explore how nurses working in KSA provide care to women with psychosis, with such care being assumed to be based on how KSA nurses think about and understand psychosis and how such thoughts and beliefs influence their practice. As a background to an investigation of this phenomenon in KSA, it is essential to analyse the international qualitative research literature from two aspects: nurses' understandings of psychosis and their nursing interventions for consumers with psychosis.

An integrative review of the literature was undertaken, and in this chapter, the background to the review, the methods and the associated findings are reported, followed by commentary on the findings in relation to the aims of this thesis. The findings of the review are explained in relation to how they informed the plan to explore KSA nurses' experiences of caring for women with psychosis. The final part of this chapter reflects on the researcher's positioning regarding the choice of the design of the research, which was based in the background work presented in the first four chapters.

4.2 Background to the review

In mental health nursing, nurses' knowledge and the interventions offered to consumers with

psychosis are essential; these nursing experiences deserve focused research attention.

However, despite the importance of nurses engaging with and supporting consumers with psychosis, there is a paucity of qualitative research into mental health nurses' understanding of psychosis and their interventional practices with consumers.

This situation is compounded by current mental health nursing textbooks, which generally offer little commentary on how mental health nurses might understand, approach, and experience caring for consumers living with psychosis. Mental health nursing practice is, of course, addressed in most contemporary nursing textbooks (Dodd & Jeffs, 2018; Evans, 2020; Hercelinskyj & Alexander, 2019; Townsend & Morgan, 2018; Wood, McLaughlin, & Owen, 2017), and generally, the textbooks provide sound guidance about the aetiology and clinical treatment of psychosis, nursing management, and principles of recovery (Dodd & Jeffs, 2018; Evans, 2020; Hercelinskyj & Alexander, 2019; Townsend & Morgan, 2018; Wood et al., 2017). These texts predominately focus on a biomedical model of care, and citations in these texts (e.g., Dodd & Jeffs, 2018; Hercelinskyj & Alexander, 2019) reveal limited evidence of nurses' knowledge and practices, and little guidance as to how nurses can engage and work with someone with psychosis. The texts provide limited guidance to mental health nurses seeking to engage in advanced practice. Further, there is little information or evidence in current published work that seeks to guide mental health nurses practising in different cultural and gendered contexts as they work with those experiencing psychosis.

More than a decade ago, Hem and Heggen (2004) noted that mental health nurses 'use themselves as therapeutic tools', and they need to be able to understand the experiences and standpoints of consumers in order to contribute to those consumers' 'well-being and personal growth' (p. 56). Hem and Heggen (2004) indicated that most research in this area focused on the abilities and qualities of mental health nurses, rather than on what they do and what

happens in the resulting therapeutic relationships. In a narrative review, McCann (2001) summarised developments in psychosocial interventions for consumers with psychosis in other disciplines, then addressed how these interventions could be used in nursing practice. McCann (2001) commented that nursing interventions at the time were fragmented and insufficient, and that trained mental health nurses needed recognition and strong organisational support. Since the early part of this century, there has been limited research on how mental health nurses intervene in their care for consumers experiencing psychosis.

Qualitative evidence related to nurses' interventions to promote recovery from psychotic illness published over twenty years (1989-2009) was the subject of a systematic review by van Dusseldorp, Goossens, and van Achterberg (2011). van Dusseldorp et al. (2011) identified five domains of care interventions undertaken by nurses working with consumers experiencing psychosis. The domains of nursing interventions identified were the development of therapeutic relationships, relapse prevention, the enhancement of social functioning, improvement in the medication adherence, and support for family members. The review drew on findings from 27 papers, the majority of which (18) were narrative reviews, practice reports, and opinion papers. Six papers reported quantitative research findings, and between them, they addressed all five domains of practice. Three research studies reported in van Dusseldorp et al. (2011) were qualitative (Forchuk, Jewell, Tweedell, & Steinnagel, 2003; McCann, 2002; McCann & Baker, 2001), and contributed evidence to the domain of 'development of therapeutic relationships'; no evidence was provided about the other four domains of practice.

Forchuk et al. (2003) found that nurses' roles change during consumers' phases of illness and recovery, and as recovery proceeds more collaboration occurs in nurse-consumer relationships. McCann (2002) reported that mental health nurses could relate to young adults with schizophrenia to develop the process of recovering hope for the future. Nurses can

develop this hope by enhancing consumers' motivation to recover and developing pathways to wellness. McCann and Baker (2001) explored how community mental health nurses develop mutual interpersonal relationships with young adults with first-episode psychosis. These relationships are advanced by the nurses' understanding consumers, being friendly with them, 'tuning in', teaching them how to reveal themselves, being there for the consumer, and maintaining consumers' confidentiality.

Despite the time since the van Dusseldorp et al. (2011) publication, and the changes to treatments since, it might be expected that the identified domains remain relevant in current mental health nursing practice. The conceptualisation of the nursing beliefs and practices of the five domains of care by van Dusseldorp et al. (2011) has generated a way of looking at mental health nurses' practices. Overall, the framework can be viewed as a basis for further research and review of evidence in this field.

The van Dusseldorp et al. (2011) review highlighted the paucity of qualitative research in the first decade of this century on nurses' beliefs and practices in the context of psychosis. There is a need for further qualitative evidence to strengthen insights into the knowledge, understandings, and interventions nurses apply when working with consumers experiencing psychosis. It is essential to review the qualitative research on nurses' understandings and interventions in the context of psychosis from the past decade in order to expand on the work of van Dusseldorp et al. (2011).

Research by Hem and Heggen (2004) was not included in the van Dusseldorp et al. (2011) review. However, Hem and Heggen (2004) investigated how consumers with psychosis may experience nurses' interventions and attitudes as rejection. The authors used ethnographic methods to study how mental health nurses employed professional boundaries within 'nurse-consumer relationships' when working with consumers, and how they managed professional

distancing and supported consumer autonomy to assist recovery. Their findings recognised that mental health nurses have a great deal of knowledge and understanding about relating to and working therapeutically with consumers experiencing psychosis, but workplace constraints in mental health nursing practice hinder the effectiveness of nurses' interventions. These findings call for further investigation of how nurses work with and overcome constraints as they seek to provide therapeutic interventions.

As qualitative research from the perspective of nurses offers insights into their understanding, and their interventions and practices with consumers with psychosis, it is important to review the evidence generated by recent studies. In addition, it is important to review qualitative evidence on the development of mental health nursing domains of practice in relation to psychosis, which has been produced since van Dusseldorp et al.'s (2011) review. The purpose of the present review is to examine the qualitative research published since 2009, as a means of investigating contemporary evidence regarding nurses' knowledge and understanding of consumers' experiences of psychosis, and nurses' therapeutic interventions and practices while caring for these consumers. Reporting this knowledge will progress insights into mental health nursing practice, and advance nurses' understanding of, and interventions in, the care of consumers with psychosis.

4.3 Methods used in the integrative review

The five-stage methodological approach developed by Whittemore and Knafl (2005) was used for this integrative review. These stages involve clarifying the problem and linking it to the research aim, searching the literature, evaluating the quality of the data using appraisal tools, undertaking the analysis of the data, and presenting the findings in a synthesised form.

4.3.1 Problem identification

Mental health nurses' understandings of and interventions for psychosis are essential for successful contemporary mental healthcare. However, only a few qualitative studies before 2009 were identified as having investigated mental health nurses' understanding of and interventions for psychosis from nurses' perspectives. The purpose of the integrative review was to examine the qualitative evidence gathered since 2009 to examine progress in the field.

4.3.2 Search strategy

4.3.2.1 Inclusion criteria

All articles were required to be about mental health nurses. The selected studies were also required to report on mental health nurses' practices, their understandings, or experiences of participating in interventions for consumers with psychotic disorders and be based on primary qualitative research or qualitative findings derived from the literature or systematic reviews. To be included articles needed to be peer-reviewed and published in English between 2009 and 2020.

4.3.2.2 Exclusion criteria

Any research about the experience of cohorts other than mental health nurses was excluded. Quantitative studies were not sought due to insufficient emphasis on nurses' narratives, experiences, and practices. Grey literature was not sought due to limitations in peer-review, potential difficulties in assessing the quality of such studies, and the risk that data may be incomplete, with vital points omitted or absent (Hopewell, McDonald, Clarke, & Egger, 2007).

4.3.2.3 Database searches

Six databases (AMED, CINAHL Plus, EMBASE, Joanna Briggs Institute, Ovid Medline, and PsycInfo) were searched using the terms outlined in Table 4.1 including MeSH headings and Boolean operators. A PRISMA Flow Diagram (Figure 4.1) adapted from Moher, Liberati, Tetzlaff, and Altman (2009) shows the search steps and associated outcomes.

Table 4.1: Terms for general searching in the databases

Subject Search Term		Alternative Search Terms for Psychosis		Alternative Terms for Care
Nurs*	AND	Psychosis OR Delusion* OR Hallucinat* OR Negative symptom* OR Schizophrenia OR Schizoaffective OR Schizophreniform	AND	Understand* OR Comprehend* OR Care* OR Intervened* OR Recover*

The initial search retrieved 5,087 papers across all databases. After removal of duplicates 3,747 relevant papers were screened. The first step in screening involved reading titles for their fit to the inclusion and exclusion criteria. The second step of screening involved reviewing abstracts based on the inclusion criteria. These two steps of screening resulted in 94 papers needing full-text review. The full-text review resulted in the exclusion of 88 papers which did not meet the inclusion criteria. Only six papers met the criteria for quality appraisal after the full-text eligibility check (see Figure 4.1).

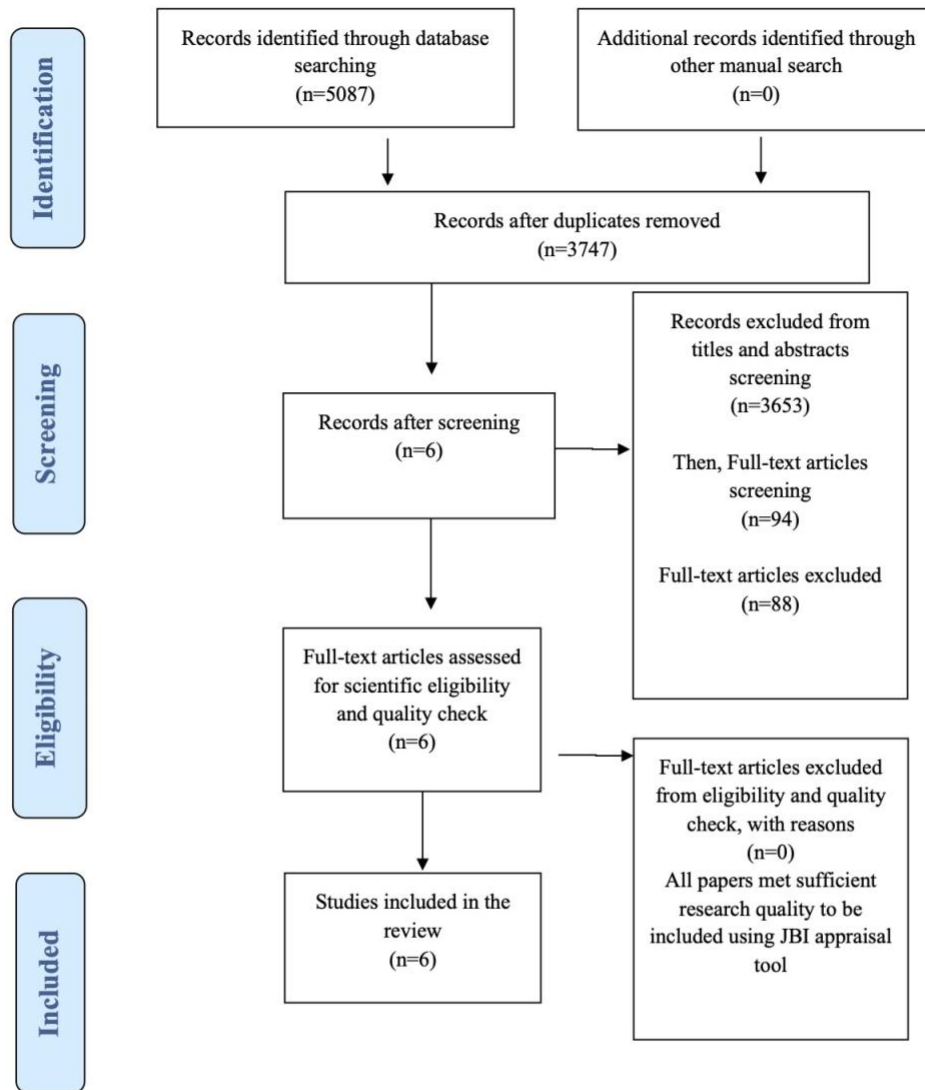


Figure 4.1: PRISMA flow diagram

4.3.3 Data evaluation (quality appraisal)

The six qualitative research articles identified as suitable were methodologically assessed using the Joanna Briggs Institute (JBI) (2017) appraisal tool ‘Qualitative Assessment and Review Instrument’ (JBI-QARI). No studies were rejected based on quality (see Table 4.2). To minimise selection bias, the student and supervisors checked the six retrieved papers during screening, assessed them for scientific eligibility, and agreed on final inclusions.

4.3.4 Data analysis

Data were analysed according to the methods described by Whittemore and Knafl (2005), which incorporate data extraction, reduction, and categorical coding to support the aims of this integrative review. All data extracted were examined and coded, compared, discussed and their features agreed by the student and supervisors. The key features which emerged from the included studies are reported in Table 4.3, while the foci of selected studies relative to the review aims are shown in Table 4.4.

4.4 Synthesis of findings

The two categories derived in relation to the research aim and the extracted data were *nurses’ understanding of psychosis* (two sub-categories) and *nurses’ interventions for psychosis* (five sub-categories) (see Table 4.4). The data analysis and integration were considerate of divergences in study designs, settings, population, and analytic procedures in the six studies.

Table 4.2: JBI Qualitative Assessment and Review Instrument (JBI-QARI) methodological appraisal

Question	Engqvist et al. (2010)	Kaewprom et al. (2011)	Moe et al. (2012)	Odeyemi et al. (2018)	White et al. (2019)	Korteland et al. (2019)
	Yes/No/Unclear/Not applicable					
Is there congruity between the stated philosophical perspective and the research methodology?	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the research question or objectives?	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the methods used to collect data?	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the representation and analysis of data?	Yes	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the interpretation of results?	Yes	Yes	Yes	Yes	Yes	Yes
Is there a statement locating the researcher culturally or theoretically?	No	No	No	Yes	No	Yes
Is the influence of the researcher on the research, and vice- versa, addressed?	Yes	No	No	Yes	Yes	No
Are participants, and their voices, adequately represented?	Yes	No	Yes	Yes	Yes	No
Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	Yes	Yes	Yes	Yes	Yes	Unclear
Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Yes	Yes	Yes
Score	9/10	7/10	8/10	10/10	9/10	7/10
Overall appraisal	Included	Included	Included	Included	Included	Included

Table 4.3: Key features of the included studies

Author	Aim	Design	Country	Methods	Participants' demographic characteristics	Setting	Key findings
Engqvist et al. (2010)	To explore RPN descriptions of presence when caring for women with PPP.	Descriptive qualitative research.	Sweden.	Secondary analysis of interview data. Thematic and categorical analysis of interviews.	N=10 RPN Female=9, Male=1 Av age=54 Av yrs. as professional =16.	Mental health centres (3).	Presence intervention of nurses used to: - Protect the women from self-destructive behaviour & degradation, protect the baby. - Facilitate recovery–calming environment, building relationships, providing hope, managing daily life, normalising reality, & facilitating bonding. - Learning from being present.

Kaewprom et al. (2011)	To explore the perspectives of nurses regarding schizophrenia and recovery.	Descriptive, qualitative study.	Thailand.	Semi-structured interviews; thematic analysis.	N=24 nurses Female=19, Male=5 Av age=41.7 Work exp in MHN range=3-27 yrs. Master's Degree in MH=13 4 months of a training program in advanced MHN=15 Both Master's degree and MHN program=7.	MH units in 2 general hospitals. 1 MH hospital.	- The nurses identified personal & environmental factors supporting & facilitating recovery or barriers to recovery.
Moe et al. (2012)	To explore MHNs' clinical practice for individuals experiencing first-episode psychosis.	Qualitative influenced by a Grounded Theory (GT) approach.	Norway.	Seven focus group interviews. Analysis: GT coding.	7 CMHCs each with a focus group. 2-7 participants in each focus group 2 had specialised early intervention team Others had generalist services in CMHC.	CMHC	The core category of nursing intervention, a process named working behind the scenes. Subcategories: 1. Keeping the consumer in mind. 2. Invisible care. 3. Invisible network contact. Ethical challenges in supporting autonomy & and avoiding paternalism are illuminated.
Oedeyemi et al. (2018)	To explore factors impacting MHNs' experiences and interventions working with people with first-time psychosis.	A qualitative descriptive study.	Ireland.	Semi-structured interviews; thematic analysis.	N=8 Registered MHN Female=6, Male=2 Exp. in MH≥2 years.	Community MH settings.	Critical MHN interventions for consumers experiencing first-time psychosis: - Relationship building. - Therapeutic engagement with consumers. - A clear pathway to care. - Develop nurse capacity through clinical supervision and training.
White et al. (2019)	To explore early career MHNs' understanding of providing care to mental health consumers who hear voices.	A qualitative exploratory, descriptive study.	Australia.	Individual semi-structured interviews; thematic analysis.	N=9 RNs employed in a mental health service. 1 in 1st yr. 3 in 2nd yr. 3 in 3rd yr. 1 in 4th yr. 1 in 5th yr. (RN5) 3 working in community 6 working in inpatient settings.	Community MH settings. Mental health inpatient units in a general hospital.	Four themes: - The importance of responding to consumers who hear voices. - The importance of developing knowledge and skills. - Struggling to achieve the role of the mental health nurse. - Practice contexts (community or inpatient units) affected the level of skills needed for therapeutic care.

Korteland et al. (2019)	To identify nursing interventions used in a mental health mother-baby unit for women with postpartum psychosis.	A descriptive qualitative study.	Netherlands.	Semi-structured interviews; thematic analysis.	N=13 MHNs Female=11, Male=2.	Mother-baby unit, psychiatry dept., medical centre.	Nursing interventions 3 themes: 1. Nurses' interventions to improve mothers with PPP, mental & physical well-being. 2. Care for the mother-baby dyad, promoting the development of mother-baby relationships. 3. Enhancing the well-being of the woman's partner.
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Key: CMHC: Community Mental Health Centres, GT: Grounded Theory, MH: Mental Health, MHN: Mental Health Nursing, N: Number of participants, PPP: Postpartum Psychosis, RPN: Registered Psychiatric Nurse, Yrs.: Years

Table 4.4: Foci of selected studies relative to review aims

	Categories and subcategories	Engqvist et al. (2010)	Kaewprom et al. (2011)	Moe et al. (2012)	Odeyemi et al. (2018)	White et al. (2019)	Korteland et al. (2019)
Category 1	Nurses' understanding of psychosis		√		√	√	
Sub-category 1	Nurses' understanding of recovery from psychosis		√				
Sub-category 2	Factors impacting nurses' understanding of psychosis				√	√	
Category 2	Nurses' therapeutic interventions	√		√	√	√	√
Sub-category 1	Engaging in the development of therapeutic relationships	√		√	√	√	√
Sub-category 2	Assisting consumers to prevent relapse			√			√
Sub-category 3	Enhancing consumers' social functioning	√			√		√
Sub-category 4	Supporting consumers' medication adherence and therapeutic alliance	√		√	√	√	√
Sub-category 5	Working with and supporting family members			√	√	√	√

4.4.1 Nurses' understanding of psychosis

Three studies (Kaewprom, Curtis, & Deane, 2011; Odeyemi et al., 2018; White, Stein-Parbury, Orr, & Dawson, 2019) contributed research evidence on how nurses understand and experience caring for mental health consumers with psychosis and two sub-categories of findings (*nurses' understanding of recovery from psychosis* and *factors impacting nurses' understanding of psychosis*).

4.4.1.1 Nurses' understanding of recovery from psychosis

Only one study contributed evidence related to nurses' understanding of recovery from psychosis. Kaewprom et al. (2011) investigated mental health nurses' understanding of and views about recovery from schizophrenia, which enabled exploration of how they conceptualised such recovery. Overall, the nurses believed that essential factors for recovery for consumers with schizophrenia included acceptance of the illness, a sense of hope for the future, and adherence to medication and treatment regimes. These nurses identified that environmental factors were also crucial in facilitating recovery from psychosis. Two key environmental factors supporting recovery were consumers' experiences of a supportive environment (mainly generated by their families and communities), and having access to appropriate mental health services. Kaewprom et al. (2011) also reported that many nurses noted that while there might be a supportive family and community situation, which could assist in recovery, stigmatisation of persons with mental illness could be a significant barrier to recovery.

4.4.1.2 Factors impacting nurses' understanding of psychosis

White et al. (2019) investigated the experiences of early-career nurses working with mental health consumers experiencing auditory hallucinations, while Odeyemi et al. (2018)

contributed findings related to the educational and supervisory needs of mental health nurses, and examined how mental health nurses gain insights into and learn about psychosis from consumers.

Being aware of the need of consumers who experience auditory hallucinations to share such experiences, White et al. (2019) were interested in whether early-career mental health nurses understood this need, and if so, how they responded to it. The participants reported their needs for additional education and better development of knowledge and skills to work effectively with consumers. Several participants reported dissonance between what they had learned during their undergraduate education about the importance of therapeutic listening and what they observed in practice, where the ‘therapeutic side of things and communication [is]... mostly done by doctors and psychologists’ (White et al., 2019, p. 611).

Odeyemi et al. (2018) investigated factors affecting mental health nurses working with consumers experiencing their first psychotic episode. The researchers identified nurses as being motivated to practise with mental health consumers based on their opportunities to make a tangible difference to individuals’ lives. The nurses also associated job fulfilment with their sense of hope for user-based recovery and any increased well-being in their consumers. In addition, the nurses in this study reported a desire to develop their therapeutic capacities and knowledge by accessing additional training and education in cognitive behavioural therapy and family behavioural therapy. Some nurses reported feeling anxiety associated with limited understanding of psychosis while providing care to consumers. However, these nurses also experienced some relief after discussing care concerns during professional debriefing and supervision with colleagues.

4.4.2 Nursing interventions for psychosis

Findings regarding the second category, nurses' perspectives on nursing interventions used with consumers with psychosis, were reported in five of the six studies. Five sub-categories emerged, and these were consistent with the five domains of practice identified by van Dusseldorp et al. (2011): *engaging in the development of therapeutic relationships, assisting consumers to prevent relapse, enhancing consumers' social functioning, supporting consumers' medication adherence and therapeutic alliance, and working with and supporting family members.*

4.4.2.1 Engaging in the development of therapeutic relationships

Five qualitative studies (Engqvist, Ferszt, & Nilsson, 2010; Korteland, Koorengevel, Poslawsky, & Meijel, 2019; Moe, Kvig, Brinchmann, & Brinchmann, 2012; Odeyemi et al., 2018; White et al., 2019) reported how nurses engaged in the development of therapeutic relationships with consumers experiencing psychosis. Odeyemi et al. (2018) reported that nurses used relationship-building to promote wellness among consumers experiencing their first episode of psychosis. These nurses also facilitated collaborative practice in their healthcare teams to support the delivery of therapeutic relationships more generally. Similarly, White et al. (2019) found that nurses sought to develop therapeutic relationships with consumers experiencing auditory hallucinations. In this case, respondents felt limited by the lack of specialist education and professional supervision, and by workplace cultures which offered limited support for such learning and engagement.

Engqvist et al. (2010) investigated mental health nurses' use of presence when caring for women with PPP. Presence is a technique which involves nurses being in contact with women based on remaining physically close to them (Engqvist et al., 2010). The nurses sit with consumers, listening to their stories and doing everyday tasks with them to allow

consumers to develop a sense of being well cared for; this technique also increases the nurse's empathy and facilitates consumer comfort and trust by creating a meaningful connection (Engqvist et al., 2010). In addition, the nurses reported using this skill to support and facilitate user-based recovery with the women they cared for by building relationships, creating calm and restful environments, assisting the women in managing their daily lives, supporting the development of hope, and normalising reality; the key was facilitating a bond between the women and their babies (Engqvist et al., 2010). Korteland et al. (2019) similarly reported the importance of relationships between nursing staff and women experiencing PPP during the phases of their hospitalisation. They identified that relationships were enhanced when the nurses provided advice and non-judgmental feedback for the mother about her baby's care.

Moe et al. (2012) expressed concern that despite guidelines being in place for health professionals working with consumers experiencing first-episode psychosis, there remained 'little information about the role of mental health nurses regarding treatment and care' (p. 517); in response, they undertook a modified Grounded Theory (GT) study to advance such knowledge. They identified that nurses commonly experienced difficulties in engaging in relationships with consumers experiencing first-episode psychosis and therefore had issues supporting their treatment regimes. In their attempts to achieve better outcomes, most nurses used methods *behind the scenes* which involved minimal consumer collaboration. One of these methods was 'invisible care' (Moe et al., 2012, p. 520), which involved building a safety net for consumers that might include planning for consumers to receive practical support or finding creative ways to engage with them. However, as these activities were primarily initiated by nurses and arranged with little consumer collaboration, this care model, while inventive and supportive, was assessed by Moe et al. (2012) as having paternalistic

overtones, as well as risking damage to consumer confidentiality and a therapeutic relationship based on trust.

4.4.2.2 Assisting consumers to prevent relapse

Korteland et al. (2019) reported that for women experiencing PPP, as their treatment progressed, the nurses believed that nursing interventions should be designed to facilitate relapse prevention strategies. Such strategies should be in place as they worked towards discharge with the consumers. The nurses, as reported by Korteland et al. (2019), sought better provision of psycho-education work on mapping pre-discharge care and safety to prevent relapse.

Moe et al. (2012) reported that nurse's work behind the scenes involved using an *invisible network* of contacts, meaning that this network was invisible to the consumers. Such interventions aimed to facilitate non-scheduled and indirect network discussions with colleagues or with the consumers' family members about how consumers were managing, both daily living activities and any symptoms. The idea behind such interventions was to prevent relapse through nurses developing networks to gain supplementary information about consumers, including symptoms, medication adherence, and daily activity, as knowing more about these aspects would enable them to give consumers targeted advice on how to manage any issues, potentially decreasing the risk of relapse.

4.4.2.3 Enhancing consumers' social functioning

Odeyemi et al. (2018) noted that nurses in their study recognised the social impact of untreated psychosis in consumers, leading to isolation and withdrawal in individuals, negatively affecting help-seeking behaviours. To overcome this issue, these nurses emphasised the importance of collaboration between mental health professionals to develop a more accurate assessment of consumers' social needs. This collaborative practice was seen as

an instrument supporting nurses' professional roles in helping consumers to reinforce their social positioning.

The nurses in the study of Engqvist et al. (2010) reported that presence as a practice was viewed as an adaptation of social skills akin to friendship-making, making it a vital addition to nurses' professional development. The nurses also used this skill to facilitate bonding between the women and their babies. All participants in this study identified that using a *presence* strategy with consumers experiencing psychosis made significant improvements to their mental health nursing practice.

The expert nurses in the study of Korteland et al. (2019) identified that a focus of their nursing interventions was promoting safe interactions between women with PPP and their babies during all phases of their illness. The nurses also worked directly with the women's partners throughout all stages of care, providing interventions to enhance the partner's capacity to engage with both the woman and the baby.

4.4.2.4 Supporting medication adherence and therapeutic alliance

Five studies which discussed interventions (Engqvist et al., 2010; Korteland et al., 2019; Moe et al., 2012; Odeyemi et al., 2018; White et al., 2019) also contributed new knowledge on how mental health nurses support consumers' medication adherence and therapeutic alliance. In Odeyemi et al. (2018), the nurse respondents recognised the importance of medication adherence in managing psychosis symptoms, with these nurses highlighting the necessity of consumers' engagement in psycho-education to support their medication adherence. The nurses in White et al. (2019), however, emphasised the importance of monitoring consumers' need for medication to assist in the control of symptoms, as well as the use of distractions to divert consumers' attention from their auditory hallucinations, and an emphasis on the use of reality testing, music, and other cognitive behavioural techniques to mitigate symptoms. In

addition, these nurses identified difficulties in communicating with consumers, particularly in assisting consumers to manage their distress and fear when they experience auditory hallucinations while trying to keep consumers safe from self-harm. These difficulties were seen as being produced by a workplace culture focussed only on risk management, leaving nurses unsupported in communicating more deeply with consumers to help manage symptoms.

Engqvist et al. (2010) examined the value of nurses using presence to help consumers cope with and recover from PPP. The nurses in this study identified that some women engaged in acts of *self-harm*, represented by degrading themselves and feeling ashamed of embarrassing behaviours performed in their acute psychotic episodes. These mental health nurses used the skill of presence to protect consumers from engaging in acts of self-harm, and to support and facilitate user-based recovery by creating calm and restful environments, assisting women in managing their daily lives, supporting the development of hope, and normalising reality.

Nurses in Korteland et al.'s (2019) study identified improving consumers' mental and physical well-being as the key foci of nursing interventions, and these foci were maintained across all phases of PPP care. Examples of mothers' interventions during the acute phase involved supporting self-care, providing information about the disorder, and working towards stability by supporting rest, reducing escalation, and facilitating reconnection with reality. As treatment progressed, the nursing interventions encompassed support activities for daily living, the provision of postpartum care, and various efforts to enhance adherence by providing education and support. As nurses worked towards the consumers' discharge, they consciously strengthened their psycho-education provision, encouraging consumer self-confidence and therapeutic adherence by mapping post-discharge care and safety.

The nurse participants in Moe et al. (2012) commonly encountered difficulties in supporting consumers with first-time psychosis with their treatment regimes. These difficulties included assessing whether consumers who did not adhere to treatment were actively refusing treatment or whether they were simply struggling due to their psychotic symptoms. To achieve better outcomes, the nurses reported using methods which did not involve collaboration with consumers, generating supportive network contacts with consumers' families and communities to achieve the outcomes the nurses deemed necessary. However, these nurses had a limited ethical perspective on this work. Further ethical reflection and awareness of the need for consumer's autonomy may be required, as these nurses' practices included future treatment planning, monitoring for appointment attendance, and interim mental health status assessments without consumer input.

4.4.2.5 Working with and supporting family members

Four studies (Korteland et al., 2019; Moe et al., 2012; Odeyemi et al., 2018; White et al., 2019) provided findings that supported the fifth subcategory of nurses' interventions; that is their efforts to work with and offer support for family members. Odeyemi et al. (2018) identified therapeutic plans and discussions between mental health nurses and their colleagues as essentially focused on the consumer's connections and the family involvement, particularly for individuals presenting with first-episode psychosis. Therapeutic plans must include the capacity for relationship building with consumers' family members. The nurses' views expressed in Odeyemi et al. (2018) demonstrated the need for family-centred care in the mental health nursing profession. However, White et al. (2019) reported that nurses in inpatient wards usually do not communicate with consumers' families, suggesting that a crucial therapeutic nursing intervention is omitted.

Korteland et al. (2019) found the nurses in their study viewed support for consumers' partners' wellbeing as an essential nursing intervention. The nurses emphasised the need to work closely with partners in all phases of illness to plan care effectively. Nurses' reported practice in Moe et al. (2012) went further, using an invisible network of family contacts to facilitate non-scheduled and indirect network discussions with consumers' families about how consumers managed daily living activities, symptom management and medication adherence.

4.5 Discussion of the findings

Overall, six qualitative studies published in the past decade reported mental health nurses' understanding of and practice strategies when working with consumers experiencing psychosis. While the findings of this integrative review are limited by the timeframe for searching, the databases utilised, the inclusion and exclusion criteria, and the scope of the methods, the results are important and relevant.

The findings of this integrative literature review both support and extend the findings of van Dusseldorp et al. (2011), which suggested that mental health nurses provide interventions in five key domains of care: the development of therapeutic relationships, relapse prevention, the enhancement of social functioning, the improvement of medication adherence, and support of family members.

The findings of the studies in this integrative review deepen existing insights into the strategies which mental health nurses use to integrate care for consumers in a transition to user-based recovery. The practice of presence (Engqvist et al., 2010) addresses the nursing practice for psychosis is essential for nurses' relatedness with consumers. This practice uses an adaptation of social skills to aid recovery and protect consumers from self-harm by

enhancing therapeutic alliances. The empathy aspect is generated by nurses developing insights into consumers' experiences (Engqvist et al., 2010). Empathy is an essential practice among mental health nurses, linked to the domain of practice concerned with developing therapeutic relationships. Another identified form of nursing intervention, however, involves working behind the scenes (Moe et al., 2012), enriching the nursing domains of practice for psychosis by overcoming difficulties in terms of engagement and forming relationships with consumers to develop a therapeutic alliance. The aim of this behind-the-scenes work is to prevent relapse by following up on consumers by facilitating networking with consumers' families. The reviewed studies deepen professional understanding of nurses' practice of presence, their ways of working behind the scenes, and their strategies for achieving integration of care and consumer transition to recovery.

As discussed earlier, Hem and Heggen (2004) investigated nurses' understanding of and interventions for psychosis, with the domain of nursing practice investigated being the enhancement of therapeutic relationships with consumers. Their study gives insights into nursing strategies supported by the current integrative review: presence, working behind the scenes, and empathy. Moreover, the dominant nursing strategy was a therapeutic relationship, which reflects the importance of nursing relationships with consumers, which, as Peplau (1991) emphasised, are central to nursing care. Overall, these strategies can enrich nurses' knowledge of caring for consumers with psychosis, indicating that nursing interventions are informed by knowledge.

The findings of this integrative review reflect how nurses understand psychosis. Kaewprom et al. (2011) revealed that nurses' conceptualisations of recovery within the context of psychosis were based on their grasp of personal and environmental factors which influence consumers' experience and recovery. Other findings regarding nurses' understanding of

psychosis and consumer care highlighted the importance placed on specialist knowledge, skills, and experience, as ways to enhance the provision of care (Odeyemi et al., 2018; White et al., 2019). Together, these studies highlight that early-career and inexperienced nurses tend to find professional supervision, support, and further education to reduce anxiety, with these factors strengthening their confidence and skills in working with consumers experiencing psychosis. This need for capacity building in the mental health workforce is further supported by Engqvist (2011), who identified that this was needed to achieve any advancements in care. To build capacity, nurses require an understanding of the process of psychosis and user-based recovery.

In a broader sense, to improve their understanding of and ability to offer interventions related to the domains of practice for psychosis, nurses must develop their skills and improve their clinical capacity to care for consumers. A step in facilitating this would be advancing mental health nursing education at the undergraduate and postgraduate levels. Immersion in mental health settings at the undergraduate level will help student nurses to develop or discover strategies that can benefit consumers and kindle or fan their desire to make a difference in the lives of individuals living with mental illnesses (Edward et al., 2015). After graduation, when nurses commence working in mental health settings, continuing education is imperative. This is supported by Cleary and Happell (2005), who found that nurses recognise their needs, and that they need more education in many areas, including assessing consumers experiencing psychosis.

In summary, the findings of the integrative review have resulted in a classification of contemporary knowledge and qualitative evidence from the field generated by qualitative research. Research related to nurses' understanding of psychosis is limited. However, the findings reveal nurses' new and emerging understanding of consumer recovery and practical

factors which affect the quality, range and depth of nurses' understanding of psychosis. A key feature of the findings was the confirmation of earlier work by van Dusseldorp et al. (2011), in which domains of nursing practice were identified. The evidence identified in this review deepens and extends these earlier findings. However, a limited number of qualitative research projects have contributed to this new evidence. There is considerable need for further qualitative research on the culture and context of mental health nurses' knowledge of and interventions regarding the care of consumers experiencing psychosis.

The context and culture of practice, which was used as a lens for this qualitative exploration in the reviewed studies, allowed the identification of the stories and accounts of participants, which enhanced the researcher's ability to analyse the culture of practice. An example of this which arises from the current integrative review is the focus on recovery-oriented practice in the reviewed studies. All these studies explored mental health nursing in different cultural contexts. As consumers may come from different cultural backgrounds, cultural considerations significantly affect nurses' understandings and interventional practices.

Based on the evidence of the five domains presented in the findings, nurses could inform their knowledge and practice by considering the findings of this review and considering the domains of their interventions and seeking to extend their understanding generally. Such improvement should begin with the enhancement of relationships with consumers, based on applying user-based recovery-oriented practice to prevent relapse, improve medication adherence, and enhance social functioning and family support. By merging these domains with the culture and context of practice, mental health nursing for consumers with psychosis can be advanced, and user-based recovery-oriented practice should be applied in all domains to support consumer improvement.

The general paucity of qualitative studies in this area reveals the need for more

comprehensive qualitative studies of nurses' interventions in care for consumers of different types at different stages of psychosis. In addition, there is a need to study nurses' interventions in multiple clinical contexts of practice, including acute inpatient and community-based services. There is an additional need for the specific investigation of mental health nurses' own perceived needs for support and further education, to determine the most effective ways of upskilling nurses to deliver contemporary evidence-based nursing interventions in all five domains of practice. By addressing these areas of research, nurses can be assisted in developing confidence and expertise in the care of consumers experiencing psychosis.

4.6 Conclusion

It is critical for the future of effective mental health care that mental health nurses are supported to advance their understanding of psychosis and of interventions to work with consumers who are experiencing it. An essential mechanism for advancing this knowledge is through undertaking qualitative research with nurses to understand the bases for their practices and the context of their care as they support the recovery of consumers with psychosis. There is yet limited qualitative research on the ways mental health nurses think about and practise in a work context. Six qualitative research studies were undertaken during the past decade to support and extend previous findings about the relevant domains of care provided by mental health nurses; there is a pressing need for further research into these domains of practice to help determine ways of strengthening mental health nurses' specialised knowledge and skill sets to support their interventions.

4.7 Discussion of the key findings of the integrative review related to the present research

This chapter offered an integrative review of the qualitative research literature reported during the last decade on mental health nursing care for people with psychosis. The review categories are discussed in the following sub-section to determine how the review findings informed the present study's exploration of KSA nurses' experiences of providing care to KSA women with psychosis. The integrative review also identified the need for studies of nurses' understandings of and interventions for psychosis in relation to gender and culture. Although there have been some additions to the literature on cultural factors, further research is needed to expand the current understanding of what it is like to be a nurse caring for consumers with psychosis, both from a gendered point of view and in the contexts of specific cultures. In the present research, inter-related aspects of gender and culture are highlighted based on the integrative review.

4.7.1 Nurses' understandings of and interventions for consumers experiencing psychosis

The integrative review examined the qualitative evidence produced during the past decade about nurses' understandings of psychotic experiences among consumers and the interventional support provided by nurses. Limited qualitative literature emerged, with only six relevant qualitative research studies identified in the last decade. The integrative review affirmed the existence of two main categories of studies: nurses' understandings of psychosis, and nursing interventions for consumers with psychosis based on their domains of practice. The present research should decrease the knowledge gap in this area and add new insights through its exploration of how KSA nurses provide care to women with psychosis and intervene appropriately in their treatment.

4.7.2 Mental health nursing care for women with psychosis

In terms of mental health nursing care for women with psychosis, the integrative review identified two studies (Engqvist et al., 2010; Korteland et al., 2019) which explored nurses' perspectives on interventions for women with PPP. However, while these studies contributed to the literature in this area, the nursing care in these studies was limited to that offered for brief psychotic disorders (postpartum). Exploring nursing care for women with psychotic disorders more generally is needed to offer more comprehensive insights into how nurses understand and provide care for psychosis in a broader sense. This suggests a need for more qualitative studies about nurses' care for women in such situations, and the aim of the present research is to add new insights into nurses' experiences of providing care for KSA women with psychosis of different types at various stages. Broadening the examination of nurses' views about psychosis may also decrease the knowledge gap and enrich women-related studies in the mental health nursing discipline.

4.7.3 Effects of culture on mental health nursing care for psychosis

The review included one study by Kaewprom et al. (2011) which examined nurses' understandings of psychosis. That study explored nurses' perspectives on recovery from schizophrenia in the Thai cultural context. The Thai community in which Kaewprom et al. (2011) produced insights was about how these nurses thought about recovery from schizophrenia in relation to the culture in Thailand which tends to treat individuals diagnosed with schizophrenia with discrimination and stigma. The nurses reflected such understandings in their focus on planning nursing care provision, combatting stigma to reduce the barriers to recovery by working with families and the community to improve the local image of schizophrenia. Kaewprom et al. (2011) findings provide a valuable addition to the current body of knowledge about nursing experiences and understandings about psychosis during the provision of care in that specific cultural context. However, as the number of such studies is

still very limited, this area requires further exploration. The knowledge gained in the present research should therefore enrich the literature significantly, as nurses' experiences of care may be impacted by religious and cultural backgrounds as discussed in Chapter One, the KSA community has several norms, beliefs, and practices that may stigmatise consumers' experiences with mental illness, particularly among women. These factors make it important to examine nurses' perspectives on the provision of care for women in relation to the many cultural considerations affecting psychotic illness.

Chapters One to Four form the background to the research study. The content presented in these chapters affirms the need for the research, and the aims and objectives of the study. In addition, the background facilitated the development of the methodological approach and framing of the study. The next section presents a commentary on how the insights gained while undertaking the background work influenced my thinking and decisions regarding the methodology selected for the study.

4.8 Researcher positioning regarding selection of research methodology

Throughout the process of developing the context (Chapter One) and literature reviews (Chapters Two, Three, and Four) of this work, many insights emerged which helped me decide how to proceed with the research. The methodology was informed by Chapter One's review of the significant cultural and religious influence of KSA's conservative community, which was deemed likely to impact women's experiences of psychosis. This aspect motivated me to frame the research inquiry to understand their perspectives on experiencing psychosis through the lenses of gender and cultural influence.

In terms of previous work on KSA mental health nursing presented in Chapter One, the nursing research was relatively old and scarce. The latest update on nurses' education and training was the first national mental health atlas (Al Habeeb & Qureshi, 2010), which found that nurses working in mental health nursing are generally identified as general nurses. These nurses start their work with consumers without prior training and rely on the in-service training offered by their mental health facilities to improve their knowledge and skills on the job (Al Habeeb & Qureshi, 2010). However, research on the general context of mental health nursing in KSA, as represented in the atlas (Al Habeeb & Qureshi, 2010), was clearly insufficient to support my planned enquiry. I decided to further investigate KSA mental health nursing by reviewing the literature on care for consumers with psychosis (Chapter Two); however, no research in this area was found. Therefore, I began to think about the research design to understand the provision of nursing care to KSA women with psychosis. I was concerned about what it is like for nurses to provide care if their qualifications are as limited, also noted by Al Habeeb and Qureshi (2010).

Based on the insights gained from Chapters One and Two, the most appropriate approach for understanding women and nurses' experiences was qualitative research. Having noted the gaps in this area regarding KSA in the first two chapters, a literature review to check the latest status of qualitative research related to the experiences of consumers with psychosis and of nurses providing care to consumers was required. The research was presented as integrative reviews in Chapters Three and Four, and while some additional insights were gained from these reviews, the research remains limited.

Researching and writing the first four chapters of this work confirmed my decision to conduct a qualitative study. This decision was based on the aims and the limitations of existing qualitative research, both in KSA and internationally. The goal is to enrich the qualitative literature related to women with psychosis and mental health nursing. Although I

was motivated to proceed with qualitative research from the beginning of the research, I waited until I had reviewed both the KSA and international literature before I made a final decision on the design. Reviewing this background was a process that made me more confident and enthusiastic about proceeding with the qualitative design for this research, as I believe that the unique experiences of women and nurses are best revealed by qualitative research.

Regarding the decision on the type of qualitative method used, van Manen's (2016) phenomenological method was suggested early in the decision process. A brief perspective on this decision is that van Manen's method appeared to be the most straightforward and transparent way to interpret each experience as unique but enabled broader conclusions and implications to be drawn through the lens of my mental health nursing discipline. Further discussion is offered in the next chapter about the reasons for this choice. I believe each KSA woman and nurse deserves this level of understanding and analysis of their experiences. This exploration was expected to be inter-related with the factors projected in the first four chapters: culture, gender, mental health nursing education and training. Understanding these experiences through van Manen's phenomenological lens will offer a novel and valuable addition to the current body of knowledge.

4.9 Summary

This chapter introduced the integrative review of qualitative research in the past decade about mental health nurses' understanding of psychosis and interventions for people with this illness. This review found only six studies in this area, which is a very small number and represents a substantial gap in knowledge in the field.

Following the review, a discussion of the findings related to the current research inquiry was offered, focussing on nurses' understandings of and interventions for consumers with

psychosis in relation to informing the development of the present research inquiry. Aspects of the integrated reviews related to nursing care concerning gender and cultural aspects were also highlighted and linked to the present study. The final section offered a reflective view of the researcher's position on the selection of the most appropriate methodology for the research. The researcher's position also influenced the selection of a qualitative phenomenological methodology for the research. Van Manen's (2016) methodology was selected as the paradigm to investigate the experiences of women with psychosis and the mental health nursing care offered to women in KSA. The next chapter outlines the methodological premises and features of the methodology used in the present research.

Chapter Five: The Phenomenology and Philosophical

Orientation of van Manen's Methodology

Certain words or certain expressions may hold personal meanings for an individual that no one else can ever fully grasp. In these senses, hermeneutic phenomenology employs a heuristic of discovery: we discover possibilities of being and becoming. (van Manen, 2016, p. xiv)

5.1 Introduction

This research adopts van Manen's phenomenology as its methodology. This chapter discusses the orientation of this methodology, to facilitate an understanding of the origin of phenomenology and provide an overview of the work of prominent phenomenologists such as Edmund Husserl and Martin Heidegger. After providing the background, the chapter considers van Manen's phenomenological approach, including his classification of lifeworld existentials and his contributions to understanding and interpreting textual forms. The final section then outlines why van Manen's methodology was selected for this study.

5.2 The origin of phenomenology

The word *phenomenology* is derived from the Greek *phainómenon*, meaning *that which appears* and *lógos*, meaning *words*, or more generally *study*; hence, the term is used to refer to the philosophical study of the structures of lived experience and consciousness (Zahavi, 2003). The main element of the phenomenological paradigm is intentionality, which Earle (2010) defines as referring to the human capacity for awareness of objects and their contextual features. However, van Manen (2016) offered a broader interpretation, arguing that intentionality involves attaching oneself to the world through research, including questioning and theorising about the world to become more fully part of it.

Phenomenological approaches to research are generally grouped into two types: descriptive and interpretive (Sloan & Bowe, 2014). Descriptive phenomenology was developed in, and is attributed to, Husserl's philosophical tenets, while interpretive phenomenology is generally attributed to Heidegger's philosophical tenets. This research utilises an interpretive or hermeneutic methodology, and this type is explained in further detail in the next section.

5.3 Hermeneutic phenomenology

Hermeneutic phenomenology was selected to understand and interpret the lived experiences of KSA women with psychosis and nurses' experiences of providing care to these women.

According to Kay, Downe, Thomson, and Finlayson (2017), hermeneutics is the study and interpretation of human behaviour; further state that hermeneutics and interpretation are interchangeable. The importance of interpretation in human understanding and knowledge arises from the constant iterative and interpretive (therefore hermeneutic) cycles that move researchers between existing knowledge and new experiences (Dibley, Norton, & Whitehead, 2018).

Hermeneutic phenomenology comprises two aspects: a phenomenology of existential understanding and the concept of hermeneutics (van Manen, 2016). The phenomenology of existential understanding refers to an understanding of life as it is lived, particularly the existential world experienced in everyday life (Pettersson, Appelros, & Ahlström, 2007).

Hermeneutic phenomenology focuses on the interpretive aspects of that existential understanding (van Manen, 2016). In the present research, the interpretation of accounts offered by women with psychosis and the nurses that provide care for them was designed to be examined based on the researcher's understanding of their lived experiences. An interpretation of these viewpoints of the lived experiences represents a form of hermeneutic phenomenology.

According to Crowther, Ironside, Spence, and Smythe (2017), hermeneutic researchers faithfully seek to reveal aspects of phenomena that are rarely noticed, described, or accounted for, in order to illuminate essential, yet often forgotten, dimensions of human experience in ways that compel attention and provoke deeper thinking. This enhanced thinking about phenomena transforms experiences over time in ways that may be surprising even for hermeneutic researchers, as they adopt new attitudes or stances to take newly unfolding and evolving questions into account (van Manen, 2014). Such researchers are also enabled to attune themselves to the phenomenon in ways that open out their practice and invite them to work with data in emergent ways (Crowther, Smythe, & Spence, 2015; Crowther, Smythe, & Spence, 2014; Thomson, Dykes, & Downe, 2011). Crowther et al. (2017) recommend a phenomenological stance which seeks ways of working with and reporting data that retain the primary open questioning stance. This stance allows researchers to be more receptive to nuances of change in their phenomena of interest as their work progresses, rather than being drawn into applying prescribed methods and anticipated meanings from an external perspective (Crowther et al., 2017).

The present research argues that many phenomena arising from the lived experiences of KSA women with psychosis and the nurses providing care to women have not previously been noted in the literature. Research based on hermeneutic phenomenology in this area is part of an attempt to illuminate the situation and provoke further thinking about the experiences of both cohorts. The researcher examined transformations and changes in these phenomena, revisiting previous questions and enabling new emergent ways of thinking, while interpreting and reflecting on existing phenomena in this research.

It is worth briefly investigating the main ideas generated by thinkers in phenomenology to see how their ideas are applied in research. A discussion about such thinkers is offered in the

next section, focusing on two prominent phenomenologists: Edmund Husserl and Martin Heidegger.

5.4 Phenomenological thinkers

Several influential thinkers have worked with the philosophy of phenomenology, developing it, and making a significant impact on its theory. Table 5.1 outlines some of the pioneering thinkers in the field with their main contributions. Edmund Husserl and Martin Heidegger are perhaps the most prominent phenomenologists, and their work gave phenomenology a scientific methodological basis. The following two sub-sections focus on these two phenomenologists, discussing their work in more detail to develop an understanding of how their contributions supported the idea that phenomenology is a suitable approach to revealing the phenomena of interest to the present study.

Table 5.1: Early thinkers in phenomenology

Thinker	Contribution
Oetinger (1702–1782)	A German pietist who studied the divine <i>system of relations</i> (Benz, 2004).
Lambert (1728–1777)	A mathematician, physician, and philosopher, known for his theory of appearances underlying empirical knowledge (Lambert, 2011).
Kant (1724–1804)	In the <i>Critique of Pure Reason</i> , Kant distinguished between objects as phenomena, including objects that are shaped and grasped by human sensibility and understanding, and objects as things-in-themselves or ‘noumena’, which do not appear to humans in space and time and about which no legitimate judgments may be made.
Hegel (1770–1831)	Hegel challenged Kant's doctrine of the ‘noumena’, declaring that by developing a more complete knowledge of phenomena, it is possible to gradually arrive at a consciousness of Divinity’s absolute and spiritual truth. This idea is most notably discussed in Hegel’s work: <i>Phenomenology of Spirit</i> , first published in 1807 (James, 2007).

5.4.1 Edmund Husserl

Edmund Husserl (1859-1938), a thinker and philosophical researcher, was the principal founder of phenomenology and one of the most influential philosophers of the twentieth century. He added several major scientific elements to phenomenology, allowing it

to be more readily utilised and adapted for the analysis of research findings (Brough, 2009). Although the term *phenomenology* had occasionally been used in earlier philosophy, Ordille (2016) highlighted that the modern use of the term is explicitly tied to Husserl's work: he is often considered the father of phenomenology, based on his alignment of the technique with the Cartesian duality model of mind and body. Husserl was a mathematician, logician, and philosopher who focused on conscious lived experience in his work, which facilitated the development of phenomenology (Husserl, 2013). Applebaum (2012) noted that Husserl also contributed to almost every area of philosophy and anticipated some of the central ideas of neighbouring disciplines such as linguistics, sociology, and cognitive psychology.

Regarding Husserl's approach in phenomenology, Hamill and Sinclair (2010) suggested that the approach describes ordinary human experiences as being perceived by each individual; it then involves four main steps: bracketing, intuiting, analysing, and describing. Polit and Beck (2008) further stated that bracketing is a fundamental methodological principle of the Husserlian phenomenological process, being a suspension of the natural attitude, which is an essential first step for the phenomenological researcher (Finlay, 2014). The natural attitude is among the notions which originated in Husserl's phenomenology. According to Chandler (2016), natural attitudes is in contrast to critical attitude, which is bracketed out from the taken-for-granted world of everyday life. Philosophical doubts about reality are also suspended, with a rejection of phrases such as *common-sense thinking* and the attitudes of everyday life (Chandler, 2016).

The next step in Husserl's approach is intuiting, which posits that any logically consistent meaning can, in principle, be subjectively fulfilled by unified intuition (Beyer, 2018). Intuition includes an act of continuous perception or intuitive imagination, allowing the structure and other essential features of meaning to be read from the respective modes of intuition fulfilment (Beyer, 2018). In terms of analysis, Husserl's application of detailed

analysis of perception and thought allowed him to develop an account of how the world's objective and structural features can be derived directly from subjects' experiences (Biagio, 2017). In the description step, which is key to descriptive phenomenological research, Husserl's phenomenological orientation provides a basis for developing research questions focused on describing the essence of the lived experience under investigation (Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016).

In terms of precedence among these Husserlian concepts, Lopez and Willis (2004) have argued that transcendental subjectivity is the principal concept to be considered. As discussed earlier, descriptive phenomenologists apply specific steps, such as bracketing (Chan, Fung, & Chien, 2013). According to Skea (2016), while phenomenological analysis must have a disciplinary attitude as explained whereby the researcher's disciplined views are applied to the findings, this occurs later, at the data analysis stage, after the description of the findings. This disciplined view then aids understanding and explanation of the investigation's findings, rather than guiding those findings.

In the present research, data analysis is affected by the researcher exploring and seeking to understand the experience of psychosis and being cared for from the perspectives of KSA women with psychosis and the nurses providing mental health nursing care. The researcher then applies her understanding gained from her examination of the current literature and her experience in mental health nursing to understand the phenomena under analysis. Women's experiences of nursing care are discussed in terms of what these experiences mean to the women experiencing them, using their words. However, at the end of the process of analysis, the researcher's interpretation is added to explore what these experiences mean and how they may be viewed within a broader context. This approach is situated within the researcher's discipline and focuses on any inconsistencies, and in particular, things which are not said to determine what is really happening (Silverman, 2017). As part of this process, the researcher

improves her reflective ability and can improve her role in generating data and co-constructing knowledge.

Essences and how they may be understood underlie Husserl's entire approach, and Crocker (2017) suggests that Husserl indicated that only pure essences are completely intelligible, as they alone constitute what is meant by being. For Husserl, the phenomenological method makes absolute knowledge of science and values the possible; employing reason and proceeding through reduction and limitation allows the mind to purify any distortions of essences, facilitating the realisation of absolute truth (Crocker, 2017).

Overall, the importance of Husserl's work arises from the establishment of descriptive phenomenological science. The four steps of his method and the concepts and ideas he uses are outlined. Disciplinary attitude is distinguished from bracketing and highlighted as the lens of this research, being the main element used in the analysis. The following sub-section discusses the second pioneer of modern phenomenology, Martin Heidegger, to explore how his methods influenced the researcher in terms of the analysis of the data.

5.4.2 Martin Heidegger

The German philosopher Martin Heidegger (1889 –1976) (Badiou, Cassin, Spitzer, & Reinhard, 2016), the second major phenomenologist relevant to this study, built upon Husserl's methods of analysis, becoming the first thinker to discuss the interpretation of phenomena. The interpretation of findings is central to the method of analysis in this research, necessitating an examination of Heidegger's concepts and ideas.

Heidegger became Husserl's assistant in 1919, studying his transcendental phenomenology; this work figured heavily in Heidegger's subsequent thinking and his development of hermeneutic phenomenology, and he was particularly notable in the course of his first lectures at Freiburg (1919-1923) and Marburg (1924-1928) (Escudero, 2013; Wheeler, 2018).

However, Husserl's understanding of phenomenology as a science of essences was eventually rejected by Heidegger, who concluded that phenomenology as it stood missed an essential means of understanding humans as existential beings (Kafle, 2011). Some scholars such as Kafle (2011) and Pernecky (2010) have explained Heidegger departure as being primarily related to the rejection of the idea of suspending personal opinions in favour of interpretive narration and description.

The publication of Heidegger's *History of Concept of Time* in 1925 and *Being and Time* in 1927 paved the way for growth in this school of thought (Kafle, 2011). A critical contribution by Heidegger was applying the word *dasein* as a referent for the individual subject. This word was produced from two words in German, *da* and *sein*, which mean *there* and *being*, respectively; however, they are usually translated as *existence* (Abbagnano, 2020).

The original works of Husserl and Heidegger generated two different and potentially even antagonistic branches or concepts of phenomenology, based on differences in their epistemology and ontology (Miles, Chapman, Francis, & Taylor, 2013). Epistemology is the study of beliefs about the origin and acquisition of knowledge (Hofer, 2004), while ontology refers to the form and nature of reality and being and what can be known about reality (Merricks, 2007). Heidegger (2001) seminal work *Being and Time* further emphasised the ontological status of phenomenology. However, Ponterotto (2005) considered that the philosophical anchors of epistemology and ontology are usually discussed independently of one another and are frequently viewed as antagonistic concepts. Nevertheless, the two approaches are related, as beliefs about how we come to know reality necessarily involve certain epistemological assumptions (Olafson, Schraw, & Vander Veldt, 2010).

Undertaking hermeneutic research in philosophy requires the embodiment of Heidegger's fundamental hermeneutic notions (Spence, 2017). Spence (2017) suggests that hermeneutic research can accommodate the cultural, historic, dynamic, and interactive natures of thinking,

being, and doing. Heidegger's (2001) approach challenges the researcher to formulate the most appropriate questions to uncover the hidden meanings of everydayness.

As the present study adopts a hermeneutic approach to analysis, the researcher must be meticulous in building up questions during the interpretation of the findings. These questions explore what it is like to be a KSA woman with psychosis and seek to gain insights into the effects of psychosis.

Subjective experience and lived experience are two concepts frequently used by phenomenological philosophers, and while they are similar, there are some differences. Subjective experiences include such diverse mental states as seeing red and feeling pain, although they may be treated as having something in common, namely that they are phenomenal, sharing the second-order property that there is something it is like to be in that particular mental state (Sytsma & Machery, 2010). Lived experiences refer to the representation of the experiences and choices of a given person and the knowledge that person gains from those experiences and choices (Chandler, 2016). Lived experiences are the main object of study in phenomenological research (van Manen, 2016). However, Lindseth and Norberg (2004) argued that the goal of such research is to determine the understandable meanings of experiences rather than to understand individuals' lived experiences as facts. This approach to lived experience reflects the depth and uniqueness of lived experience for each individual, rather than each experience being expected to have something in common with all other experiences in a commonality which reflects subjective experience. Paley (2014) further argued that although Heidegger's philosophy does not mention lived experience, the concept is embedded in the subject-object dualism which he attempted to dismantle; Heidegger-inspired qualitative research is, therefore, the study of lived experience. Husserl and Heidegger, as renowned phenomenologists, both made significant contributions to the development of phenomenology. Their works have been basis for the development of

approaches to contemporary phenomenological research. However, van Manen (2016) has created a specific hermeneutic phenomenological method which is used in the present study. Van Manen (2016) used parts of the work of both Husserl and Heidegger, which allowed him to develop a version of interpretation which offered a helpful fit with human sciences research, including health sciences. Van Manen's (2016) phenomenological approach is the focus of the next section.

5.5 Van Manen's phenomenological approach

As the methodological approach used in this research, van Manen's phenomenological hermeneutic approach must be further analysed unpacked and discussed. Max van Manen is a notable pioneering phenomenologist who developed a distinct approach to hermeneutic phenomenology, explicitly connecting phenomenological and hermeneutical approaches in human science research (Tarozzi & Mortari, 2010). According to Magrini (2012), van Manen can be considered an educational researcher who adopted phenomenology in his pedagogical research. He also disputed different aspects of both descriptive and interpretive phenomenology (van Manen, 2017) and attempted to integrate the ideas of both Husserl and Heidegger in his praxis, which meant that he did not strictly follow the thoughts of either Husserl or Heidegger (Giorgi, 2006). Concerning his understanding of hermeneutic phenomenology, he wrote:

Hermeneutic phenomenology tries to be attentive to both terms of its methodology: it is descriptive methodology because it wants to be attentive to how things appear...let things speak for themselves; it is an interpretive methodology because it claims that there are no such things as uninterpreted phenomena... Moreover, even the facts of lived experience need to be captured in language, and this is inevitably an interpretive process. (van Manen, 2016, p. 180)

Phenomenological human science is also defined by van Manen (2016, p. 11) as 'the study of lived or existential meanings to a certain degree of depth and richness... phenomenology

attempts to explicate the meanings as we live them in our everyday existence, our lifeworld’.

Phillips (2014) and Heinonen (2015) describe the critical features and methods of phenomenological research as epoché (bracketing) and reduction. Epoché deals with freeing the mind of assumptions, while reduction deals with returning to the sources of people’s experiences. Epoché and reduction are critical components which work together in phenomenology, with reduction being that sharp turning towards the world with an open mind developed by epoché (Heinonen, 2015). Van Manen used these two features in his methods, emphasising the practice of a certain level of reduction to arrive at and reflect on an understanding of the essential structure of the thing under investigation (van Manen, 2016).

In the present study, the researcher, while analysing findings from KSA women with psychosis, might find that some women believe that they do not need to take any medication. The researcher required bracketing of all her knowledge of mental health nursing to examine the women’s perspectives. This process is necessary to evoke the concrete nature of the women’s lived meanings while attentively reporting and describing their justifications for their beliefs. Bracketing and reduction are therefore established at relevant stages of analysis.

The necessary methodological structure for such research was organised into six activities:

- (1) Turning to the nature of lived experience.
- (2) Investigating experience as we live it.
- (3) Reflecting on essential themes.
- (4) The art of writing and re-writing.
- (5) Maintaining a strong and oriented relation to lived experience.
- (6) Balancing the research context by considering parts and the whole. (van Manen, 2016, p. 30-31)

The study required KSA women’s lived experiences of psychosis to be investigated as they are lived. After clustering the data and identifying themes and sub-themes, the researcher continued to reflect on these experiences within the framework of the major themes. The

entire hermeneutic analysis ensured a balance in all parts between the presentation of findings, the interpretation of phenomena, and the researcher's reflection.

Another significant component of van Manen's methodology is the idea of lifeworld existentials, which form an essential part of the analysis and are the focus of discussion in the following sub-section.

5.5.1 Van Manen's lifeworld existentials

The lifeworld existentials of lived experience that are of most interest to phenomenologists were originally classified by van Manen (2014) into six existentials: lived space (spatiality); lived body (corporeality); lived time (temporality); lived human relations (relationality); lived things; and lived cyborg relations. These existentials were adopted as part of the current research process of inquiry, and the following sub-sections discuss these in more detail, linking them to the study aims by offering specific examples.

5.5.1.1 Lived space (spatiality)

Spatiality in phenomenology is defined as the experience of space which impacts the subject's overall experience of the world (van Manen, 2016). This study encouraged KSA women with psychosis to reveal their experiences with spatiality, particularly after admission to hospital. In this way, the hospital space was explored about its impact on their overall experience of psychosis, exploring the question of whether the design of the space aided or hindered the healing of study participants.

5.5.1.2 Lived body (corporeality)

According to Kongsuwan et al. (2016), the lived body perspective describes participants' inhabitation of their bodies relative to their experiences. In this study, KSA women with psychosis were encouraged to discuss how their illnesses impacted their bodies. Hearing

voices is a key symptom related to the women's bodily experiences, and such embodied experiences may affect their ability to proceed with full functionality in their everyday lives.

5.5.1.3 Lived time (temporality)

For van Manen (2016), temporality reflects the way in which time seems to speed up when people are enjoying themselves or to slow down when they are bored. It also offers a way to know more about people based on learning what they feel constitutes their past, present, and future, where such knowledge can be assumed to represent the horizons of their personal landscapes (van Manen, 2016). Kupke (2005, p. 203) explains lived time in this way: 'lived time is not a time that is lived and gone forever, not a dead time that is only open to knowledge, but the remaining, or better, the continuing substance of our life'. An example that links lived time to the findings in this study relates to the period of admission to a mental health ward for KSA women with psychosis and the link this has with the realisation of their need to seek treatment and start their process of recovery to facilitate discharge.

5.5.1.4 Lived self-other (relationality)

The lived self-other refers to the 'lived relation we maintain with others in the interpersonal space...we share with them' (van Manen, 2016, p. 104). For the KSA women with psychosis in this research, this lived self-other reflects the interpersonal spaces they share with others, including their families and nurses, which influence their experiences of their illnesses.

5.5.1.5 Lived things (materiality)

In his most recent method text, van Manen (2014) added lived things (materiality) as one of two extensions to his original set of four existentials:

Since things have significant effects on our existence, in almost every research study, we could ask the question 'how are things experienced?' and 'how do the experiences of the things and world contribute to the essential meaning of the phenomenon?' (van Manen, 2014, p. 306)

In this research, KSA women with psychosis were asked to describe their initial experiences of illness, including the events and causes to which they attributed their first episode of psychosis.

5.5.1.6 Lived cyborg relations (technology)

The rapid development of the current technological era caused van Manen (2014) to add lived cyborg relations as an addendum to his initial existential themes; he distinguished five types of lived cyborg relations inherent in the human experience of things and technology in the modern world:

- Experiencing technology as taken-for-granted;
- Experiencing technology ontically;
- Experiencing technology ontotheologically;
- Experiencing technology as technics; and
- Experiencing technology aesthetically (van Manen, 2014, pp. 308-309).

5.5.1.6.1 Experiencing technology as taken-for-granted

This concept is used by Van Manen (2014) to explain how technology facilitates users' lives in an unregarded manner:

Our lifeworld is increasingly changed through ever-newer forms of technology that make life more comfortable for those who can take advantage of new technologies...more cumbersome for those who are less inclined to keep up with the latest gadgets and media. (van Manen, 2014, p. 308)

The KSA women with psychosis in this study may perceive technology as a natural part of their recovery experiences, as it facilitates communication with others, allowing them to share their experiences of and ideas around recovery.

5.5.1.6.2 Experiencing technology ontically

In terms of experiencing technology ontically, van Manen remarked, ‘Scholars like Ihde, Dreyfus, and Achterhuis have been trying to determine how the various digital technologies, such as computers and hand devices, and features, such as the internet and online activities, can be understood’ (van Manen, 2014, p. 308).

5.5.1.6.3. Experiencing technology ontotheologically

Technology was described by van Manen (2014, p. 308) as ‘a way of revealing’ in his attempt to determine how technology can be experienced ontotheologically: this concept gives humans the resources to ‘let things reveal themselves’, and this may be particularly relevant to people’s use of the internet, which may be hoped to reveal the sources of the information they seek.

5.5.1.6.4 Experiencing technology as technics

Technology as technics has an enormous effect on modern life, particularly with regard to the ways in which younger people may become ‘caught up’ in technological innovations, such as developing a preoccupation with online games or excessive use of social media on smartphones (van Manen, 2014, p. 309).

5.5.1.6.5 Experiencing technology aesthetically

Van Manen discusses this point in detail, indicating that many studies have explored how technology can be experienced aesthetically and highlighting some of the more significant work done in this area as exploring ‘the role of eros, desire, and sexuality in today’s experience of the aesthetic of things and the experience of technology’ (van Manen, 2014, p. 309).

5.5.2 Textual forms

Vocative and philological methods in textual forms are vital parts of van Manen's phenomenological method of analysis. This study incorporates van Manen's textual forms of analysis in the accounts of multiple KSA women with psychosis, particularly where they present their notes or drawings representing their experience of illness. Van Manen (2014) discusses the vocative dimension of the philological method in this context, which offers another powerful form of unveiling; by doing this, he sets out to explore appropriate textual forms to be used in the pre-analytical stage of knowing.

These philological methods are discussed in depth under five separate headings: lived thoroughness, nearness, intensification, pathic, and epiphany. According to van Manen (2014), lived thoroughness is a method that aims to 'bring experience vividly into presence through the power of experiential anecdote, expressive narrative, or qualitative imagery' (van Manen, 2014, p. 206). Nearness, however, is an evocative method, which 'gives key words their full value...so that layers of meaning get strongly embedded in the text' (van Manen, 2014, p. 213). The invocative method is intensification, and for phenomenological texts, it requires the researcher to 'discern when and how words do this' and to 'be sensitive to the ways that words and expressions may acquire a certain desirable intensity when they are composed with the strongly embedded meaning' (van Manen, 2014, p. 222). Van Manen (2014, p. 228) further explains that the pathic (convocative) method of approaching text aims to 'possess the [em] pathic power to appeal - so that its life meaning speaks to, and makes a demand on, the reader'. The final method is the provocative method or epiphany, which 'articulates the kind of ethical predicaments that are suggested in the phenomenon that is being studied, and what are the active normative responses: advice, policies, tactful practices, and so on' (van Manen, 2014, p. 239).

In this study, some KSA women with psychosis discuss their experiences of symptoms through the creation of narrative notes or by drawing images to explain some of their experiences. One woman, for example, writes a poem with keywords expressing her sadness about her admission experience and trauma arising from seclusion. The researcher needs to give her words total value and be sensitive to both the word choices and the underlying expression of sadness, which acquires a certain intensity based on the robustly embedded meaning. The woman's words possess a specific power in terms of making demands on the researcher during interpretation. The poem suggests a response to the quality of mental health services and nurses' care that restrictive practices on consumers might be otherwise limited. As the layers of this poem's meaning are embedded in the text, it can be used in the pre-analytical stage, unveiling that which is otherwise embedded, including the woman's dissatisfaction with hospital services or nursing care.

Based on this discussion of van Manen's phenomenological method and its components, it is worth highlighting the importance of phenomenology in nursing research. This is the focus of the next section.

5.6 Phenomenology and nursing research

The researcher is a mental health nurse, and as a phenomenological approach has been adopted, it is helpful to highlight the previous use of phenomenology in nursing research. As a discipline, nursing is concerned with studying the entire human condition, and respect for people's uniqueness is an integral feature (Earle, 2010). Gallagher, Sasso, Bagnasco, and Aleo (2014) also argue the need for nursing research should be addressed as any other field of research. However, Gallagher et al. (2014, p. 857) admit that, while in some countries 'nursing research is well developed and acknowledged as a legitimate and necessary basis for nursing activities', in other countries, 'nurse researchers encounter resistance, scepticism, and

misunderstanding in relation to qualitative research and philosophical scholarship in particular'. Earle (2010) suggested that nursing scholars who have employed the phenomenological approach have made notable contributions to nursing knowledge and highlighted that phenomenological research in nursing has seen tremendous growth in recent decades. Some researchers have used a descriptive phenomenological perspective in nursing research, and others have adopted an interpretive paradigm (Welford, Murphy, & Casey, 2012). Others also have taken up a pragmatic approach supported by the application of van Manen's method to clinical nursing practice (Grant, 2014).

Qualitative inquiries in nursing which utilise lived experience can take two directions, depending on whether they use conventional or post-structural qualitative inquiry perspectives. The assumptions of conventional qualitative inquiry can be viewed as a descriptive Husserlian method which includes the presentation of the research participants' authentic voices, literally reflecting the worlds of coherent participants and researchers (Grant, 2014). This approach was first widely used in the 1990s by nursing scholars, including Cutcliffe (1999); Ens (1999); Pieranunzi (1997), and continued in the first decade of this century by Berg and Hallberg (2000); Coombes and Wratten (2007); Maddocks, Johnson, Wright, and Stickley (2010).

The post-structural qualitative inquiry perspective has been suggested for adoption in mental health nursing research by researchers including Grant (2014). This approach uses a Heideggerian interpretation of voice which moves away from a literal representation of voice to facilitate important implications for mental health nursing (Grant, 2014). Grant (2014) claims that the adoption of this approach enables new subjectivities to enable varieties of difference between voices, rather than forcing the continued replication of the thematic categories' characteristic of qualitative studies of conventional lived experience.

This study adopts van Manen's (2016) approach to hermeneutic phenomenology, which offers specific guidelines for using phenomenology as an approach in a way which builds on the experience of previous nurse researchers, who have used these guidelines to conduct studies based on the lived experiences of consumers and nurses. The researcher, in this case, as a mental health nurse, sought to determine how consumers in such circumstances live their lives and how nurses care for them, particularly in the case of KSA women with psychosis. The phenomenological approach developed by van Manen (2016) was selected to reveal what it is like both for KSA women to experience psychosis and for nurses to provide care to women suffering from the illness, and it is hoped that it may provide new insights in nursing research.

In support of the usefulness of phenomenology in nursing research as the major central orientation of this thesis, a more in-depth discussion of phenomenology and psychosis research is offered in the following section. This discussion is based on an examination of the experiences of living with psychosis and being cared for, which is the central focus of this study.

5.7 Phenomenology and research on psychosis

To gain an understanding of psychosis, phenomenological philosophy collects data from the narratives of individuals with psychotic experiences and the reports and analyses of various professionals who share phenomenological experiences (Kusters, 2016). In this study, the accounts of KSA women experiencing psychosis are examined together with the accounts of the nurses who provide care for them. This section highlights the position of phenomenology in the existing research literature on psychosis and presents some examples of its use in the present study.

At the beginning of this study, the researcher had a choice of other qualitative approaches, such as Grounded Theory. While Benoit, Moro, Falissard, and Henckes (2017) state that GT is used frequently in the field of social sciences and links subjective experiences (individual narratives) to social processes (professional norms and mental health policies), as this thesis does not focus on social processes, this approach was deemed irrelevant. Instead, its goal is to conduct a deep exploration of the meaning of women's experiences of psychosis, including the effects of social and cultural norms and women's health policies on the psychotic experience, and to gather participants' thoughts and views on what it is like to experience psychosis. Moreover, the study also requires nurses to express their perspectives on what it is like to care for women with psychosis in KSA, and this narrative is not limited to professional norms and mental health policy but incorporates the experience of caring for women with psychosis.

Another choice for this study could have been the narrative approach to explore the experience of psychosis. According to Patton (2015), this approach uses inductive thematic analysis of interview data; the data are subject to repeated rounds of coding to allow themes to emerge. Such themes can be seen as common threads in the narratives of women with psychosis and the nursing staff who care for them. However, the researcher selected a phenomenological approach which allows experiences to be explored for their richness without reducing them to shared themes.

The choice to use van Manen's (2014) lifeworld existentials in a phenomenological approach assists in revealing many aspects of the experience of psychotic illness. Examining the lived space defined by van Manen (2014) allows exploration that an individual with psychosis may struggle with the dimensions of space and find it challenging to attain a comfortable space, such as at hospital or their home (Parnas & Henriksen, 2016). One aspect of van Manen's (2014) lived body lifeworld existential can be seen in how a person with psychosis may find

that their body is changed and affected by various symptoms, especially the negative symptoms represented by diminished emotional expression or avolition (APA, 2013). Such symptoms are frequently associated with a level of neglect for body care and hygiene, even when consumers had a neat and organised appearance before their illness, for example. Concerning lived time as identified by van Manen (2014), individuals with psychosis, who are often diagnosed at the end of adolescence and in early adulthood, may effectively lose that period of their lives due to repeated psychotic episodes and time spent in hospital or in confinement at home. These episodes cause them additional struggles with school, university, or work and render them unable to participate in the ordinary day-to-day life of others of their age. Regarding van Manen's (2014) lived self-other, a person with psychosis might struggle to develop relationships with others, based on hearing voices or delusions that make a person suspicious and mistrustful about formulating relationships with others. In the context of psychosis with lived things, as described by van Manen (2014), numerous things and events can trigger aspects of this illness, such as when consumers have hallucinations which potentially encourage them to hurt self and/or others due to previous abusive or traumatic events. Finally, concerning van Manen's (2014) lived cyborg relations, a person with psychosis may be significantly affected by contemporary social media; for example, individuals with paranoid ideas might believe that their thoughts have been hacked and broadcast on social media.

5.8 The significance of van Manen's phenomenology for this study

As an experienced mental health professional, the researcher is interested in examining the lived experience of psychosis to understand the different experiences of women with this illness in KSA. Moreover, as a mental health nurse, the researcher suspected that the experience of offering nursing care to women with psychosis in KSA might be unique, or at

least different from the Western mental health contexts generally examined in the existing literature. To explore the phenomena of the lived experience of psychosis for KSA women and examine the nursing care experience of nurses looking after this group of women, the researcher chose van Manen's methodology to interpret the reports of these experiences. This decision was made due to the various supportive features of van Manen's methodology, which allow for greater understanding and interpretation of these phenomena in the KSA context.

To date, no other qualitative research has explored the experiences of women with psychosis or of nurses working with women with psychosis in KSA. It is hoped that the selected methodology offers both novel and rich understandings of these experiences in the KSA mental health context. The methodology offers both insights into the experience of psychosis and being cared for and alternate perspectives on the mental healthcare system and the unique culture of KSA in relation to these experiences. The methodology also facilitates the development of insights into the provision of better nursing care for KSA women with psychosis, which might help future nurses working with such women. These insights may also help improve the KSA mental healthcare system generally by developing ways to help women with psychosis recover and assist nurses to provide better care to women. The researcher also suggests that van Manen's methodology is easy to grasp, simple to understand, and effectively illuminates the experiences of both cohorts, and assists in developing the discussion and interpretation of her views on these perspectives through her specific professional lens.

5.9 Summary

This chapter has offered a brief review of phenomenology, specifically hermeneutic phenomenology as adopted for this research, followed by an overview of prominent

phenomenological thinkers, particularly Edmund Husserl and Martin Heidegger, who influenced the development of van Manen's method, which is used in the analysis of this study's findings. Van Manen's approach, including the six lifeworld existentials and textual forms analysis, was then outlined, focusing on how these features support the analysis. Nursing as the research discipline and psychosis as its focus are linked to the phenomenological approach with a discussion to reflect the researcher's reasons for selecting this approach. Finally, the significance of van Manen's approach to the aims of this study was outlined.

The next chapter discusses the design of the methods for this study, including the settings, participant recruitment, interview techniques, ethical considerations, and analytical considerations.

Chapter Six: Research Method

6.1 Introduction

This chapter details the application of the selected methodology to facilitate the achievement of the aims of this study, based on the hermeneutical phenomenological methodology developed by van Manen (2016), as discussed in the previous chapter. This chapter offers a discussion of the context of the research, the selection and recruitment strategies used, the method of data collection applied, the process of data analysis, the various ethical considerations relevant to the research, the authenticity of the research process, and the participants' demographic detail.

6.2 Research context

The study was conducted in two hospitals in Riyadh, KSA, identified as Hospital A and Hospital B to preserve participant confidentiality. Hospital A specialises in mental health, and there are more female inpatient wards in Hospital A than in Hospital B. Hospital A has three female wards: the short stay ward (known locally as the acute ward), the long stay ward (known locally as the chronic ward), and an addiction services ward. The study was conducted only in the female short stay and long stay mental health wards, and in the mental health OPDs. The research in Hospital B was conducted in the mental health OPDs and in the single female inpatient ward.

6.3 Selection and recruitment of participants

Ethical approval for the study was given by MOH research committee for Hospital A (see Appendix 6), and by the Institutional Review Board (IRB) for Hospital B (see Appendix 7). Site access for the study was given for the wards and OPDs. At Hospital B, site access was

granted much more quickly than at Hospital A, and audio recording of interviews of both consumers and nurses was approved. In contrast, several delays in site approval at Hospital A were caused by restrictions regarding both the recruitment of women with psychosis and the audio recording of the interviews. Since the hospital research manager at Hospital A felt that such recording represented an invasion of consumer confidentiality, the researcher agreed not to audio record the women and adopted a different strategy to address the loss of women's audio recording at this hospital. This issue is addressed in *sub-section 6.4.5*.

After gaining site approval at both hospitals, a purposeful sample of participants was recruited. The study was intended to gather information about a diverse range of experiences to examine different perspectives in mental health nursing across both facilities, and almost equal numbers of nurses were recruited from both institutions to facilitate this. However, in relation to the exploration of the experiences of women with psychosis, most respondents (14) were drawn from Hospital B, and seven were recruited from Hospital A. However, as van Manen (2014) argues, 'the use of the notion of sampling presupposes that one aims at empirical generalisation, and that is impossible within a phenomenological methodology' (2014, p. 352). He also suggests that, if the notion of the sample must be used, 'it is best to do so with reference to the attempt to gain *examples* of experientially rich descriptions' (p. 352). This study followed van Manen's lead in adopting the notion of a sample that best facilitated access to rich descriptions of the experiences of both consumers with psychosis and the nurses that provide care for them. In phenomenological studies, the size of the sample is insignificant; what is important is the saturation point, that point in the data collection process after which no additional issues can be identified and data begin to repeat, when further data collection become redundant, and this point is dependent on the phenomenological questions posed (van Manen, 2014). Participant recruitment was continued until saturation was reached in terms of the lived experiences of both cohorts of interest. As the data collection proceeded,

constant exploration of the identified themes and testing of the relationships between themes was undertaken to guide further data collection. This primary analysis sought to flesh out and explain the emergent themes and relationships until no new themes could be identified because no new categories of information emerged from further participants (Kerr, Nixon, & Wild, 2010). The fact that a data saturation point was reached implies that the data collection was sufficient for the analysis to proceed.

6.3.1 Participant recruitment

The strategy for identifying the potential pool of participants and then recruiting them is summarised in Table 6.1.

Table 6.1: The recruitment process

Participant Group	Recruitment Identification	Individual Recruitment Process
Women with psychosis	A potential pool of women with psychosis who were identified by the head nurses, charge nurses, or other nursing staff.	The researcher met the women and planned a meeting if they agreed to participate. The time and venue for the interview were agreed upon to convenience. The researcher explained the project and provided documentation, including consent forms. Which were then signed by women when they agreed to participate.
Nurses	Nurses were recruited by advertising, through flyers and meetings.	When the nurses expressed interest in participation, arrangements were made to meet according to their availability. Interviews were arranged at a time and venue according to convenience. The researcher explained the project and provided documentation, including consent forms. Which were then signed by nurses when they agreed to participate.

6.3.1.1 Women with psychosis

Women with psychosis from the inpatient wards and OPDs were identified as potential participants based on lists of women with diagnoses of psychosis provided by the relevant nursing professionals, including the head nurses and charge nurses. These lists were reviewed by the researcher with those professionals to create a shortlist of women who met the

eligibility criteria (Table 6.2). In this way, the eligibility of each potential participant was ascertained prior to them being invited to participate.

Table 6.2: Inclusion and exclusion criteria for women with psychosis

Inclusion and exclusion criteria for women with psychosis	
Inclusion criteria	Adult 18-64 yrs. A diagnosis of any psychosis disorder. At least 1 month after an acute episode.
Exclusion criteria	Age below 18 years. Intellectual or cognitive disability. Co-morbidity with another mental disorder. Within 1 month of acute symptoms

The identified women were then informed about the research during a face-to-face meeting with the researcher, thereby ensuring that all participants were aware that the research was voluntary, and that all had reasonable communication skills and were able to consent at the time of interview. Further details of this process are provided below. The total number of women who showed an interest in the research was not counted by the researcher. Several potential participants from Hospital B refused consent because they or their families did not want the interviews to be recorded. As a KSA woman herself, the researcher believes that this rejection may have been based on community mistrust of the recording of women's voices. No participants who gave consent after passing the eligibility checks withdrew, and no significant levels of distress were reported by the interviewed women which might have required the cessation of interviews or withdrawal from the study.

The inclusion criteria for women included being aged from 18 to 64 years old and having a diagnosis of psychosis. The psychotic disorders were those listed in DSM 5 (2013): schizophrenia, schizoaffective or schizotypal disorders, catatonia, delusional or brief psychotic disorders, schizophreniform, and PPP. The disorders were expanded to include mood disorders such as depression, mania, and bipolar disorders, encompassing a specific set of symptoms related to psychosis (APA, 2013). The women participants had their last acute

episode at least one month before the study. Women younger than 18 years of age or 65 and older, and women with intellectual or cognitive disabilities, other comorbid mental disorders, or acute symptoms within the last month were excluded. Each eligible woman who showed an interest was invited to a meeting with the researcher at a mutually convenient time and place, at which point the project was explained to them, any questions they had were answered, and their written consent was obtained. The consent forms used are given in Appendices 1 and 2. Overall, seven women with psychosis were recruited from Hospital A and 14 from Hospital B.

6.3.1.2 Nurses

In this study, the term Registered Nurse is used for all RNs working in mental health services, including both those who had not received any mental health training and those with specialist mental health training in areas such as principles of mental health care, symptomatology and mental disorders, psychosocial interventions, and psychotropic medication. RNs were invited to participate in the research by means of recruitment flyers and during meetings with the researcher, which were followed by personal invitations to participate. To be included in the research, each nurse had to be permanently employed in a mental health unit and to have been in such a role for a minimum of six months; this stipulation was intended to exclude casual staff and those who had only recently taken on the role (Table 6.3). Of the twenty-one nurses who volunteered, eleven were from Hospital A and ten from Hospital B.

Table 6.3: Inclusion and exclusion criteria for nurses

Inclusion and exclusion criteria for nurses	
Inclusion criteria	Experience working with mental health consumers greater than 6 months. Permanently employed.
Exclusion criteria	Experience working with mental health patients less than 6 months. Casually employed.

6.4 Data collection process

6.4.1 Developing rapport

Based on my experience as a mental health professional, the vulnerability of the participants, particularly the women with psychosis, was carefully considered in terms of power relationships, and several measures were introduced to build rapport. During this process, I monitored each participant to assess whether any potential distress might emerge. The strategies used to build rapport included the provision of a warm welcome and the adoption of a non-judgemental demeanour (Holloway, 2017). Green and Thorogood (2018) suggest that, to build trust among participants, personal sharing and a friendly approach are helpful. All participants were initially orientated to the research by the researcher and an initial informal chat was undertaken to build rapport and to foster a more relaxed environment.

6.4.2 Interview venue

All participants were asked about their preferred interview times and spaces in the hospital, with a particular focus on avoiding the potential for interruption inherent in conducting interviews in a hospital or clinic setting as far as possible (Green & Thorogood, 2018). A secure meeting room was booked in each hospital to prevent this, and to ensure privacy and confidentiality. The nurse in charge of the relevant unit prepared the room for interviews where participants agreed to this option, and this strategy was applied for the inpatient wards of both hospitals. At the OPDs in Hospital B, an unoccupied treatment room was also kept free every day to provide space for the spontaneous arrangement of interviews.

6.4.3 Interview style

In-depth semi-structured interviews, conducted in an open and exploratory fashion, were selected as the most appropriate method of collecting data for this study (van Manen, 2014).

The research was guided by the need to ask open-ended questions regarding the nurses' experiences in terms of providing care for women with psychosis and the latter's experiences of illness. Liamputtong (2013, pp. 240-241) argued that 'semi-structured interviews, built [up of] a short series of broad open-ended questions, help [in the] investigation of people's experiences'. The maintenance of interviewer focus did, however, necessitate the development of a list of themes of interest, leading to the semi-structured in-depth interview style being adopted to ensure adequate exploration of the nurses' and women's experiences while maintaining research focus. The interview guidelines can be found in Appendix 3.

In terms of the interview questions for women with psychosis, the experiences of recovery after discharge were elicited through the inclusion of a question in the interviews asking women specifically about their experiences of recovery after discharge. The researcher determined during the process of examining the literature discussed in Chapter Three, that an overall examination of experiences of psychosis necessarily includes a recovery element. This added emphasis on recovery after psychotic experiences on discharge was incorporated as a separate question in the interviews.

6.4.4 Interview techniques

Learning about in-depth interview techniques is suggested by Liamputtong (2013) before beginning research in earnest as a useful step for novice researchers. As a mental health professional, I had previously conducted many interviews with consumers. However, in acknowledgement of my status as a novice researcher, I also practised in-depth interviews with friends and colleagues to develop the necessary skills and identify aspects of best practice prior to beginning the study. These interviews were audio recorded, and the recordings then used as a resource for further improvement. Holloway (2017), speaking about hermeneutic phenomenological research, notes that a conversational interview style is the best way to generate data. Van Manen (2014) describes the specific purpose of hermeneutic

phenomenological interviews as being the exploration and gathering of experiential narrative material that may form resources for developing a richer and deeper understanding of a given human phenomenon. Developing a conversational relationship with each interviewee in this research was set as an aim to allow exploration of the meaning underlying their experiences. The researcher sought to gather rich descriptions of the lived experience of psychosis from women who had experienced this phenomenon, examining their perceptions alongside the experiences and perceptions of the nurses providing care for the women.

Initial informal discussions were held which aided my quest to develop conversational rapport with participants, and the recorded section of each interview began only when participants were settled and comfortable. The first formal question for nurses, intended to trigger an initial exploration of the phenomenon of working with women with psychosis was: 'Describe your experience and understanding of caring for women with psychosis as a nurse'. However, some nurses tended to answer this question by offering facts about psychosis and had to be gently redirected to their personal experiences, with an explanation that the study was more interested in their understandings of the phenomenon than any textbook knowledge.

The women with psychosis were also occasionally reluctant to speak freely, frequently declining to volunteer details about their experiences without researcher prompting. There are several possible reasons for this, including one of the major negative symptoms of psychosis, poverty of speech, where the consumer has a lack of conscious thought, which may impede discussion. Another possibility is simply the fact that divulging intimate and sensitive information is difficult. Further closed probing questions were asked to elicit details, such as 'do you mean you experienced hallucinations?' When such questions were answered in the affirmative, suitable open-ended phrases such as 'tell me the story of these hallucinations' were then used to encourage continuation in a more open manner. These additional questions

enabled the free flow of conversation and offered the interviewees further opportunities to talk about topics relevant to the original open-ended questions.

Several of the women were visibly emotionally moved during their interviews, offering responses that included long silences, tearfulness, and deep sighs. The researcher used her previous experience with consumers to deal empathically with participants while working to steer the conversation to a more effective rhythm. When women became emotional, they were asked if they wished to discontinue the interviews and were reminded that they had the option to withdraw from the study at any time. No one availed themselves of this opportunity, although two women requested pauses in recording while they recomposed themselves, and another asked for a pause to enable her to discuss a family conflict in a manner that she did not want recorded. After all such pauses, recording was resumed, and the interviews were completed.

Unlike the women with psychosis, the nurses tended to be more objective about their emotional attachment to the subject matter, generally allowing recording throughout. However, one of them did ask for recording to be paused when she wanted to talk about a conflict with her senior nurse; recording was resumed after this interlude.

The interviews with women with psychosis lasted for around 25 minutes on average, while the interviews with nurses lasted for between 13 and 41 minutes, at an average of around 22 minutes. Many of these interviews were shorter than ideal; in the case of the women with psychosis, their male relatives rushed women home because of the time of the interviews, women in KSA are not permitted to drive, and most were brought to their appointments by a male member of their family. The other possible reason for the women's short interviews was poverty of speech, which is a negative symptom of psychosis where the consumer lacks the capacity to express her thoughts in a detailed discussion.

In the case of nurses, short interviews were mainly caused by some inpatient nurses being pressured by senior staff to return to work as quickly as possible due to staff shortages. Such understaffing presented an additional challenge for conducting interviews with nurses across the board. In contrast to the inpatient nurses, the interviews with the OPD nurses were much more easily managed. The OPD nurses knew the regular peak times of their clinics and when clinics were not being held, allowing them to organise suitable times when they could complete the interviews without rushing.

6.4.5 Interview sessions

Data were collected by means of a series of single-session, audio-recorded, semi-structured in-depth interviews, with just one exception to the single-session premise. One woman with psychosis had her first session cut short due to a prearranged appointment; a second session was necessary to complete the interview which took place immediately after the appointment. Before interviews commenced, general demographic data for each participant were obtained. Field notes were written in all cases where audio-recording was not permitted, a circumstance which applied to the interviews with all seven women from Hospital A, due to the restrictions imposed by that hospital, and one woman from Hospital B, who asked for no recording to be made. I took notes during these interviews with the aim of capturing key points while attempting to retain a focus on the women involved. While field notes are not the best method of data gathering, the restrictions applied by Hospital A meant that they were the only permissible way to capture the women's thoughts about their experiences of psychosis. However, on the recommendation of my supervisor, a further approach to bridging the gaps inevitable in field note analysis was adopted. While the researcher was taking field notes, the women were invited to draw or write down anything they felt represented their experience of psychosis, including their feelings and thoughts during psychotic episodes. Their experiences

with nursing care or services in the facilities were also explored through the medium of their creative expressions.

In phenomenological methodology, although the tradition tends to rely on textual analysis, art can be utilised to complement this by providing insights into human thought and allowing participants to articulate their experiences in multiple forms (Smith, 2018). Similarly, when participants write about their experiences, the process enables them to reflect on both mundane and influential moments in their lives: the act of writing allows the past to become more meaningful (Mirivel, 2011). As van Manen (2016) explains, ‘writing mediates reflections and action’ (p. 124). An option to create art can also provide a mental break, a physical space, and an opportunity to think more deeply (CohenMiller, 2017). Most of the women invited to do so responded well to this request, and the strategy offered the researcher further access to insights into what it is like for women in KSA to experience psychosis.

6.4.6 Researcher reflection on interviewing women with psychosis in Hospital B

As a researcher, I was very enthusiastic about interviewing the women in Hospital B, as many had bipolar disorder with psychotic features, yet were mostly stable at the time. This allowed me to communicate with them with relative ease, as many of the consumers did not experience incoherence or poverty of speech, despite these being symptoms commonly associated with psychosis (Dominguez, Saka, Lieb, Wittchen, & van Os, 2010; Lyne et al., 2013). A major factor which aided the initiation phase of my relationships with these women was that they all trusted me as an Arabic-speaking mental health researcher. This was especially clear in Hospital B, where the women in the inpatient ward who chose to take part in the study were keen to share their experiences. Their enthusiasm and joy were clear during my visits to the ward, and they requested that I remain for longer than intended, frequently

mentioning their discontent with the nurses there on the ward being unable to understand their language. They noted that they would like to have more Arabic-speaking staff on duty in the ward. This important issue of language differences will be explored in depth in analysis chapters, as several participants discussed this in the interviews.

The levels of engagement there increased my sense of confidence initially; however, my experience at the OPD was different. At that stage, I prepared a list of potential interviewees with psychosis, to interview each day of the week. On each day, the aim was to discuss the research with 10-20 women who met the criteria, but at best only one or two participants were willing to take part each day. Sometimes an entire week passed with only two participants agreeing to engage in the study. This was a frustrating time, particularly following the positive responses I had received in the inpatient ward.

While OPDs could theoretically be interviewed after their appointments, almost all planned to leave the hospital immediately after they were seen by staff. Given women in KSA were not permitted to drive, most of them were brought to their hospital appointments by a male member of their family, as their time was limited, as the men had to take the women home and then return to work. I understood this and acknowledged that the women were invariably under pressure to leave. However, the difficulties encountered regarding the recruitment and interviewing of women were difficult for me to manage, and I often felt disheartened, particularly due to the high refusal rate and the lack of sufficient willing interviewees. Even when the women were keen to talk, they were likely to be under time constraints. It was difficult for me to maintain my enthusiasm for the project at that time.

Some individuals also declined participation due to their suspicion of audio recording. Some women felt that audio recording was an invasion of their privacy and most feared having the recordings publicised. It was difficult to obtain women's consent for audio recording of interviews, and I needed to understand and support their choices. Despite my best efforts to

reassure them regarding the confidentiality of the research data collection and storage processes, these assurances did not result in their participation.

Some potential participants were also lost because their family members refused permission for recordings to be made. Most women were accompanied by family members, who generally refused audio recording, even after being offered a clear explanation of the ethical measures in place to protect confidentiality. Many family members said, 'Write everything you like, but do not record; we do not trust audio recording storage'. This presented a significant challenge to my attempts to conduct interviews in the OPDs.

The experience of recruiting participants became a struggle that I had to prepare for every day in that unit, and even the positive energy acquired from my experiences in the inpatient ward was insufficient to sustain me. The staff members were also unable to help, and sometimes the charge nurse could not find empty rooms for interviews, as the clinics were all busy and the areas were occupied.

Despite the ethical considerations regarding recruiting and consent to participate being addressed before the interviews began, this difficulty in sourcing willing women participants for in-depth interviews posed a dilemma. At the beginning of most interviews in Hospital B's OPD, there was also a great deal of uncertainty due to the issues noted about time constraints. However, having meticulously complied with the ethical standards set out for this process, I was able to confirm that I had adhered to the required ethical practices with respect to all the women who agreed to participate in this research.

6.4.7 Researcher reflection on interviewing women with psychosis in Hospital A

Most women in Hospital A were admitted for longer stays than those in Hospital B. Collecting data in Hospital A was challenging, however, as many women there were

experiencing negative chronic symptoms of psychosis, such as social withdrawal and poverty of speech (De Berardis et al., 2013). Nevertheless, many women were cooperative and welcomed the opportunity to be interviewed.

In Hospital B, it was easier to interview women with psychosis because the ethical committee there approved the audio recording of interviews, while Hospital A refused audio recording, although it accepted the taking of field notes. Although phenomenological methods delve into narratives that lead to understanding people's experiences through the stories they tell (Davidsen, 2013), field notes cannot record exact narratives or quotes from participants. However, the women's use of items written or drawn during the interview process was adopted as a supplementary method to address the potential gaps in field note analysis (see Sub-section 6.4.5). This dual approach was viewed as adequate for this research, taking account of the restrictions imposed by Hospital A. Many women with psychosis in Hospital A had rich experiences of long or frequent hospitalisations, and their interviews were of great value in developing deeper understanding of such experiences. To have omitted these entirely due to a lack of recordings would have removed much depth from the study.

I was excited to use this method of looking through the lens of the women's own writing and drawing, informed by the phenomenological approach, as it permitted the observation of the women's own experiences as illustrated by them, and addressed the challenges associated with conducting the analysis from field notes. As discussed in the previous chapter in relation to these drawings and written notes, van Manen's (2014) approach can be utilised to analyse all textual forms, and in this case, I took it as both a challenge and opportunity to explore what lay beneath the texts.

6.5 Data analysis

The data were analysed in accordance with van Manen's (2016) hermeneutic phenomenological method, with thematic analysis undertaken based on the six lifeworld existentials used on participants' evidence to reflect their experiential and interpretative realities. The drawings and notes of participants were also analysed regarding these six lifeworld existentials alongside the analysis of the textual feature (van Manen, 2014). These methods were used to generate themes to support more accurate interpretation and to offer access to the lived experiences of participants in relation to psychosis or caring for women with psychosis.

As argued previously (see Section 6.3), the necessary data collection was performed in a manner which was mindful of the requirements of the data analysis process and the need to achieve data saturation. Langford (2013, p. 143) stated that data analysis generates a 'thick description that accurately captures and communicates the meaning of the lived experience'. To capture and communicate these meanings, however, a novice researcher needs to develop an understanding of what such meanings are. To enable understanding and identification of themes in this study, the following points by van Manen (2016) were utilised to enable the development of an appreciation of the constituent parts of the relevant themes:

- The theme is the experience of focus, of meaning, and of the point.
- Theme formulation is, at best, simplification.
- Themes are not tied to a single encounter at certain points or moments in a text. A theme is not a thing; themes are intransitive.
- The theme is a way of capturing the phenomenon the researcher is attempting to understand. The theme describes an aspect of the structure of lived experience. (p. 87)

These points assisted in the development of an understanding of what to look for both within the data collected and during the process of data collection. One example, the sub-theme *the*

need for a healing space, which was identified from analysis of the nurses' interviews, fits the criteria above because this sub-theme

- was composed of the experience of several nurses, reflecting their need to work in a space conducive to healing for women with mental illness.
- is simplified, in that it reflects one specific need for people working in a space which does not currently help them to offer the best possible care.
- does not objectify any single encounter within the nurses' perspectives but instead emerges from the overall idea that these nurses work in spaces that do not currently promote healing.
- captures the phenomenon of nurses' work in KSA mental health spaces and the structure of nurses' lived experiences as reflected in the current lack of healing space.

Isolating themes constitutes only the initial step of data analysis; the greatest illumination of the phenomena of interest lies in the writing and rewriting process (van Manen, 2016, p. 77).

To generate initial themes from data, van Manen (2016, pp. 92-93) suggests three approaches:

1. The *holistic or sententious approach*, in which the researcher considers the text, asking which pertinent phrase may best capture the fundamental meaning or main significance of the text, with attempts made to express that meaning by formulating such a phrase.
2. The *selective or highlighting approach*, where the researcher listens to, or reads, a text several times, and asks what statement(s) or phrase(s) arising from it are particularly essential to or revealing about the phenomenon or experience being described. These are then circled, underlined, or highlighted in some other way for further investigation.

3. The *detailed or line-by-line approach*, in which the researcher looks at every sentence or sentence cluster and asks what that segment reveals about the phenomenon or experience being described.

This study utilised the highlighting approach, with texts being read several times and ongoing work being done to identify and mark the statements that best reveal the phenomena being described regarding both the experiences of women with psychosis and nurses' experiences of providing care to women with psychosis. Moreover, as some women with psychosis had made drawings and written notes, it was also appropriate to utilise van Manen's approach to analysing a variety of textual forms. In a powerful unveiling, van Manen (2014) discusses one of his *Philological methods: the vocative* by setting out to explore textual forms that might be used in the pre-analytical stage of knowing, addressing the vocative methods in great depth under five headings: Lived Thoroughness, Nearness, Intensification, Pathic, and Epiphany, all of which were examined in detail in Chapter Five.

6.5.1 Analysing the texts

To generate themes from the data, van Manen's (2016) process was employed. Audio recorded interview data were transcribed, and the transcripts checked against the audio recordings, a process which facilitated the examination of the recordings and transcripts several times to highlight the various salient emotionally driven features such as silences, deep sighs, pauses, and significant phrases. All the women with psychosis spoke Arabic, and the resulting transcripts were translated into English for further analysis. The eleven Arabic transcripts from the nurses in Hospital A were also translated into English. Once all transcripts had been translated into English, the data in the transcripts were then extracted, taking all pieces into consideration to obtain better contextual understanding. The statements that best revealed the phenomenon being described in terms of the research aims were

underlined, and the field notes and women's drawings and notes were used to highlight any additional related phenomena noted in their interviews.

Major themes were identified, highlighted, and clustered; these were reviewed by the research supervisors for confirmation (see Table 6.4) before being structurally analysed on the basis of the lifeworld existentials introduced by van Manen (2016). The aim of this process was the development of a deeper understanding of both experiencing psychosis and being cared for in KSA based on an examination of the lived experiences of both consumers and the nurses who care for them. Figure 6.1 highlights the process of data analysis begun by considering van Manen's (2014) six lifeworld existentials and textual forms analysis as a means to facilitate theme and sub-theme clustering and identification. This process was based on describing how differences in views were identified and integrated into the overall picture. Table 6.5 reveals the three main lifeworld existentials that framed the nurses' themes: lived space, lived body, and lived self-other. The identified themes, and the ways in which they cluster alongside the sub-themes from the texts created by women with psychosis, are shown in Table 6.6, while the findings and analysis of both cohorts' texts are described in more detail in the analysis chapters.

Table 6.4: Developing themes and weaving the lifeworld existentials

Texts	Subthemes	Themes	Lifeworld Existential
‘We do not have a garden outside, so most of the [consumers] saw this ward as a jail because it is a closed one because they [do] not understand why it is closed... so like it is a punishment for them’. (Nurse)	The need for a healing space.	Nurses’ perspectives on working in mental health facilities in KSA	Lived space
‘I wish if they could provide gardens and liberate us to get out to the garden of the hospitals.’ (Woman with psychosis)		KSA women’s experiences of living with psychosis after admission to or follow-up from a mental health facility	
‘What I know about psychosis is that the consciousness of the [consumer] is different from normal, the [consumer] forgets some important things, and she does not know how to wear her clothes, eat or behave. She is not aware of reality as if she was newly born’. (Nurse)	Hospital A nurses’ understandings of psychosis	Nurses’ experiences of providing care to women with psychosis in KSA: understandings and emotions	Lived body
‘At my room in the hospital, I hear the TV sounds coming from the hall, but I hear different words...I used to hear sounds and explain it in another way’ (Woman with psychosis)	Experiencing psychosis symptoms and insight into psychosis after admission	KSA women’s experiences of living with psychosis after admission to or follow up from a mental health facility	

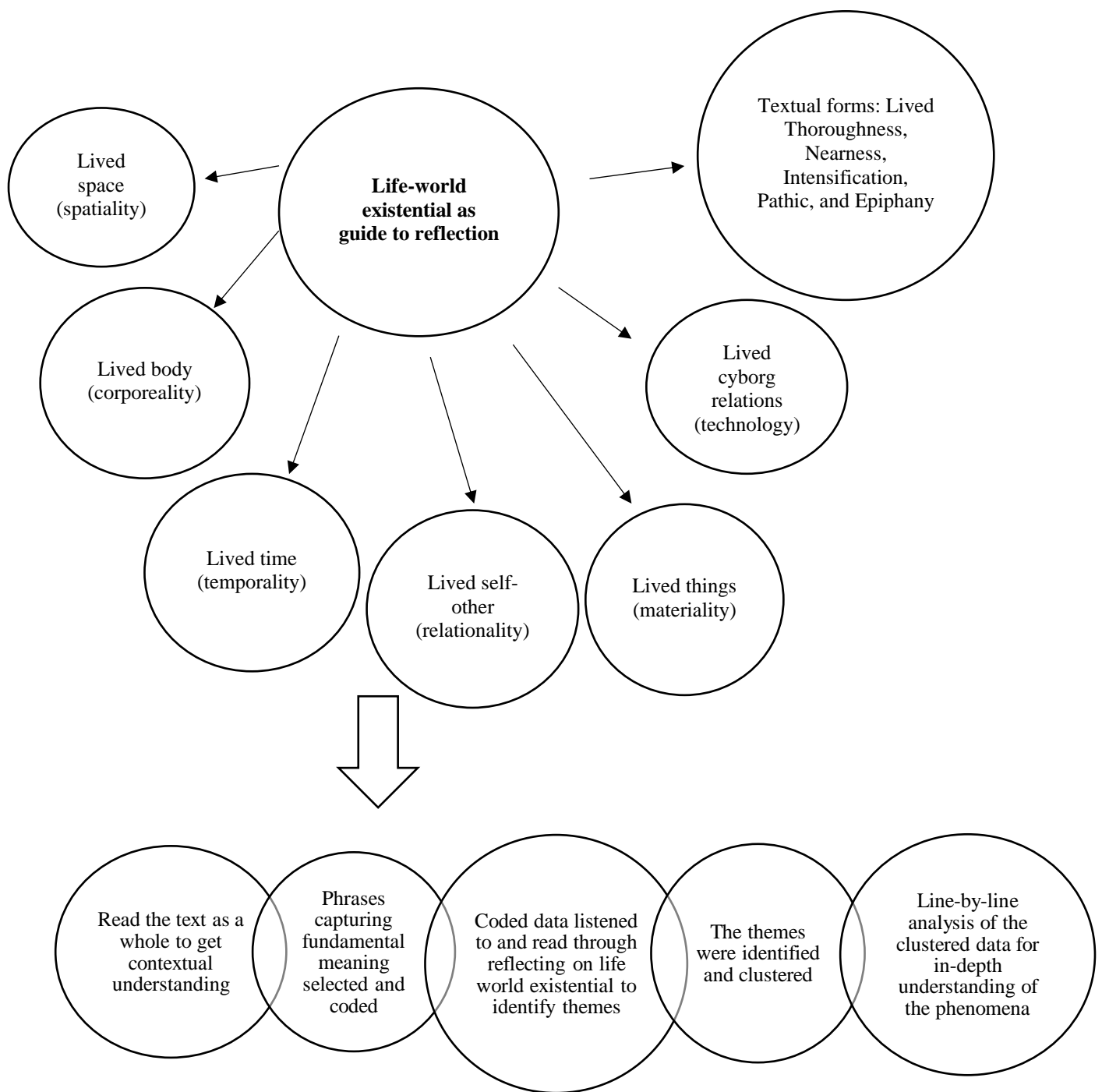


Figure 6.1: Process of data analysis

Table 6.5: Lifeworld in mental health nurses care experiences for women with psychosis: Three major themes

Life World Existentials of Mental Health Nursing Care for Psychosis in KSA	
Lived space	Nurses' perspectives on working in mental health facilities in KSA
Lived self-other	Nurses' experiences of care for KSA women with psychosis: lived self-other
Lived body	Nurses' experiences of providing care to women with psychosis in KSA: understandings and emotions

Table 6.6: Thematic development: Women with experience of psychosis

Major Themes	Sub-themes			
Women in KSA and their lived experiences of first episode psychosis	Understanding of psychosis cause.	Experiencing the onset of psychosis symptoms, with developing insight into the illness.		
KSA women's experiences of living with psychosis after admission to or follow up from a mental health facility	Admission or follow up experiences.	Experiencing psychosis symptoms and insight into psychosis after admission.	Experiences with services and nursing care.	The need for a healing space.
KSA women's experiences of living with psychosis in the community after discharge from the mental health facility	Experience of medication adherence.	Living with family, friends, and the community.	Recovery from psychosis symptoms and insight into illness.	Experiencing recovery in terms of education, employment, and religion.

6.6 Ethical considerations

This research received ethical approval from the Monash University Human Research Ethics Committee (Review reference: 2017-1246-10907) (see Appendix 5), as well as conforming to the *National Statement on Ethical Conduct in Human Research* produced by the National Health and Medical Research Council (2007). In addition, ethical approval was gained from both hospitals involved in the data collection process, as the research was considered high risk, due to the vulnerability of consumers with psychosis who are central to the research. Multiple ethical issues were examined, including the risk of unanticipated harm, the need to protect participant information, the need to effectively inform participants about the nature of

the research, and the risk of exploitation. A structured approach was applied to such considerations, utilising the three ethical principles of respect for people, beneficence, and justice, as outlined by *the Belmont Report* (1978). During the interviews, no participants disclosed any challenging information that required escalation or further protective action, and no unexpected issues were encountered during the data collection period. There was a single potential exception, which involved a consumer who talked about an experience of questionable practice by one nurse. Although the nature of the allegation was serious, the event was reported as having occurred a long time previously and the woman in question showed no evidence of discomfort or distress during the interview. Since there was no clear procedure within that facility for the reporting of historical issues with the quality of nursing practice on behalf of a participant, this matter was not taken further.

6.6.1 Informed consent and voluntary participation

The practice of informed consent is important, and it serves to protect all those who participate in research studies. According to Marshall et al. (2014), the process of obtaining informed consent centres on the idea of voluntary participation and the ability of individuals or their surrogates to comprehend information provided about study goals and risks. They must also be clear about their ability to withdraw from any study, and be able to understand that they have individual choice in the matter and not feel that they are being coerced in any way (Marshall et al., 2014). The need to minimise the possibility of coercion or undue influence for participants is also stated by the *Common Rule for the Protection of Human Subjects* (Porter, 1991). In this study, participants were reassured at all stages that their involvement in the study was voluntary, and that they had the right to withdraw from the research at any stage without consequence. Participants were also informed that they could stop the interviews at any time if they wanted to. Participants who were audio recorded were given the option to turn off the recorder if they wished to not have certain aspects of their

interviews recorded. In Hospital A, as the recording of the interviews was prohibited with women with psychosis, the research instead relied on a combination of researcher field notes and the notes and drawings made by participants during their interviews, as discussed earlier. During the interviews in Hospital A, all participants were informed that they had the right to ask the researcher not to take notes if there was anything they wished to have excluded from the research.

The recorder was stopped in the middle of the interviews by four participants due to heightened emotional states or preferences for certain portions of the interviews not being recorded. Three of these cases occurred in interviews with women with psychosis who became overwrought and asked for a moment of silence before recording resumed. The fourth participant was a nurse, who asked for the recording to be stopped because she wanted to talk about how her managers dealt with nurses, information she did not want included in the research.

Two consent forms (Appendices 1 and 2) and explanatory statements were developed for the relevant participant groups. The explanatory statements provided information about the participants' rights and how the research would be conducted, and each participant was also offered a brief verbal overview of their rights before their interview. All participants were also asked to read the explanatory statements and consent forms at that stage. Once participants had no further questions, each participant signed a consent form, and the interviews were carried out at the agreed times and venues. Written informed consent was obtained from all interviewees participating in the research.

6.6.2 Minimising harm to participants

A process to manage any potential distress caused by the research was developed, and this was outlined in an explanatory statement. The explanatory statement clearly noted that there

were no anticipated risks to participants in participating in the research beyond the normal rises in stress levels that might occur when discussing their experiences. However, a plan was set in place to ensure that if any participant did become significantly distressed, the relevant interview would be immediately terminated, and they would be referred to a counsellor at the hospital. Interviewees were monitored carefully for discomfort, with actions being readied to avoid and manage any discomfort among participants, supported by my experience as a mental health nurse. Each participant was also given the appropriate telephone numbers of support personnel, included in the consent form, in case of any ensuing adverse consequences. The research manager from Hospital A and the IRB coordinator from Hospital B supported this process, offering their telephone numbers to give to participants in case any adverse effects emerged from the data collection process. Following the interviews, no indication was received from any participants that they required these services, and many of the consumers and nurses noted that they were grateful for the opportunity to discuss their experiences.

6.6.3 Privacy and confidentiality

To ensure the privacy and confidentiality of participants, several strategies were employed, including the coding of data, the use of pseudonyms applied consistently throughout the thesis and in all publications, and the secure storage of data. Coding numbers were given to all participants, with the women with psychosis being allocated WWP1 to WWP21 and the nurses allocated N1 to N21. Permission was also sought from all the participants to use their de-identified data for research purposes.

All interviews were initially transcribed by the researcher, with the resulting Arabic transcripts then professionally translated into English to ensure accuracy and to save time. The professionally certified translation service selected also provided a declarative guarantee that all transcripts would remain confidential. Unfortunately, the initial translation required

revision, as a several descriptions of medical terminologies and symptoms were not translated in a way which accurately reflected the content and context of the interviews. Indeed, it eventually became clear that the translator was not experienced or proficient in dealing with medical texts, resulting in the need for a full check and revision that largely negated any anticipated time savings.

6.6.4 Data storage, access, and disposal

Based on university requirements, the collected data must be stored in a locked space or in password-protected e-space for five years. They will then be destroyed after this five-year period has elapsed. This strategy was explained to participants to ensure they were aware of how their information would be managed and to reassure them that their confidentiality was assured. The consent forms are also stored separately from the transcripts, and the project supervisors have not been made aware of the identities of any participants.

6.7 Rigour

According to van Manen (2014), rigour in phenomenological research can be a challenging concept. In particular, phenomenological researchers can find it difficult to defend their work where they must overcome language issues and where criteria are applied that are not appropriate for evaluating the quality or the rigour of the selected research process (van Manen, 2014). It is important for nurse researchers to bear in mind the fact that certain fundamental notions in phenomenology, such as rigour, also differ in application from the same notions as applied in other qualitative methodologies (Errasti-Ibarrondo, Jordán, Díez-Del-Corral, & Arantzamendi, 2018). This section discusses the methods used to develop and retain rigour throughout this study. Two measures of rigorous phenomenological research are examined: validity and reliability, and these are linked to this study to help develop an understanding of how any threats to rigour were addressed.

6.7.1 Validity

Van Manen (2014) argues that ‘measures such as content validity, criterion-related validity, and construct validity apply to tests and measures that are not compatible with phenomenological methodology’ (p. 347). He asserts that, while these various checkpoints may be applicable to other types of qualitative research, they cannot be applied to phenomenology because of the major differences in purpose between phenomenological enquiry methods and other methodologies (van Manen, 2014). The primary aim of the phenomenological method is ‘to gather prereflective experiential accounts’ (van Manen, 2014, p. 311). Van Manen (2014) therefore claims that ‘a common problem for phenomenological researchers is to be challenged in defending their research in terms of references such as sample criteria, members’ checking and empirical generalisations that do not belong to the methodology of phenomenology’ (p. 347). This leads to the argument that the following four questions are those which are vital to phenomenology (van Manen, 2014, pp. 350-351):

Is the study based on a valid phenomenological question?

This study sought to understand the phenomena of psychosis as experienced by KSA women and the experience of providing care to women by nurses based on the overriding phenomenological questions; ‘what is having psychosis like?’ and ‘what is it like to care for women with psychosis?’ These formed the starting point for the study.

Is analysis performed on experientially descriptive accounts or transcripts?

The analysis in this study was performed on the descriptive accounts generated by participants as transcribed by me and checked by my supervisor and another academic colleague. The supervisor read the transcripts to advise on any important issues that might require additional focus on relistening to the recorded interviews. Additionally, the Arabic

recordings were listened to and checked by an Arabic academic colleague, who also checked the translated transcripts. Thematic analysis was then performed in accordance with van Manen's (2016) hermeneutic phenomenological method by generating themes to facilitate accurate interpretation and to gain access to the lived experience of participants in relation to psychosis and nursing care for women; these are found in the results chapters. Following this process, the focus was on the development of these themes.

Is the study properly rooted in primary and scholarly phenomenological literature?

In this study, a wide range of scholarly work by phenomenological philosophers and researchers was explored to help develop a better understanding of this philosophical tradition. A wide range of nursing research has also been driven by phenomenology, and this was used to support the understandings generated by the study. Primarily, the focus was on the use of van Manen's (2016) methodological outline for hermeneutical phenomenological research and writing, as this study is based on this approach.

Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other (non-phenomenological) methodologies?

Various researchers have suggested different methods that can be used to ensure trustworthiness in qualitative research. For instance, Holloway (2017, p. 302) claims that 'researchers make judgments of trustworthiness possible through developing dependability, credibility, transferability, and confirmability'.

6.7.2 Reliability

The reliability of a study refers to the generation of the same or at least similar results each time the same study is repeated; van Manen (2014, p. 347) states that, for phenomenological studies, inter-rater reliability cannot be considered, because 'phenomenological studies of the same *phenomenon* or *event* can be very different in their results. A phenomenologist may

study the same phenomenon that has already been addressed repeatedly in the literature but strives for new and surprising insights'. In terms of the present study, it must also be acknowledged the experience of psychosis differs based on the point at which it occurs in a person's life, as well as on that person's personality and experiences. Psychosis is a subjective experience influenced by many factors: exploring the experience of psychosis at one point may produce very different results from an examination of its manifestation at another, and the same researcher is also likely to receive new insights each time the same questions are asked.

It is important to distinguish between empirical and phenomenological evidence; van Manen (2014) argues that phenomenological evidence is based on 'intuitive understanding and is meaning-based and based on the logic of eidetic reduction . . . and is ambiguous and never complete' (pp. 350-351). He further notes that, while empirical evidence is based on objective data, phenomenological evidence is solely based on the subjective experiences of participants and researchers' interpretations of those experiences (van Manen, 2014). Therefore, phenomenological evidence cannot be generalised, and van Manen (2014) criticises those qualitative researchers who try to generalise evidence, suggesting that 'the only generalisation allowed in phenomenological enquiry is [that it is] never generalised' (p. 351).

In the context of the present study, the experience of psychosis described by participants must be seen, therefore, as unique to this cohort; any other cohort will have had a separate and unique set of experiences. The meaning of psychosis elicited in this research therefore cannot be viewed as representing a generalised sample. However, van Manen (2014) suggests that one way to make phenomenological generalisations possible is to 'adopt existential and singular generalisations' (p. 351) which refer to a phenomenon in both the existential and unique senses. For example, many women and nurses interviewed expressed the existential

and unique sense of the need for a healing space, a singular generalisation which was adopted as a theme. The women and nurses used this singular idea to illustrate multiple aspects of their responses to mental health facilities, including the lack of gardens, concerns about cleanliness, and issues with activities. These different aspects shared the same existential driver, however, which was that the current facilities are not optimal for healing. This is an example of a singular generalisation arising from this research.

6.8 Trustworthiness of data

Data collection was continued until saturation was attained, after which all recordings were transcribed. All nurses' interviews were recorded, with ten of these being in English and the remaining 11 in Arabic. All 13 recorded interviews with women with psychosis were in Arabic, while the eight sets of field notes for the non-audio recorded interviews of women with psychosis were written by the researcher in English.

The audio recordings of the interviews with 21 nurses and 13 women with psychosis were accurately transcribed verbatim, thereby further enhancing trustworthiness. The main credibility issues that arise regarding trustworthiness concern the focus of the research, particularly the possible degree of confidence in how well the data and processes of the analysis address the research aims (Koehn & Lehman, 2008). The data generated by the interviews with women with psychosis and the related analysis address the research aim in terms of exploring the experience of women with psychosis, and their experiences of receiving care from nurses. In addition, the nurses' data and the subsequent analysis address the research aim in terms of examining the care of KSA women with psychosis, which means that any credibility concerns must be considered adequately addressed.

Confirmability, another part of trustworthiness, refers to 'the degree to which the results of the inquiry could be confirmed or corroborated by other researchers' (Baxter & Eyles, 1997,

p. 505). Confirmability is ‘concerned with establishing that data and interpretations of the findings are not figments of the inquirer’s imagination but are clearly derived from the data’ (Tobin & Begley, 2004, p. 392). This meant that I, together with my supervisors, repeatedly re-examined the work to confirm that the analysis remained firmly based upon the data.

The third facet of trustworthiness is transferability, which refers to ‘the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents – it is the interpretive equivalent of generalisability’ (Tobin & Begley, 2004, p. 388). While transferability or generalisability has been discussed in detail in the reliability sub-section, it is worth reiterating that, due to the nature of this research, it is not possible to transfer or generalise the results of the study to any other context, consistent with the ideas of van Manen (2016), who stresses that phenomenological studies should never be generalised. While the thick descriptions and purposeful sampling deployed in this research could, according to Bitsch (2005), facilitate transferability of judgment, this study’s results cannot be applied to any other context due to the phenomenological approach applied overall. The present research therefore makes no claims of meeting the condition of transferability.

Taking confirmability as the final aspect of trustworthiness, as mentioned previously, the English transcripts of the nurses’ interviews were checked by my supervisor based on the first ten minutes of each interview, and any errors in the matching transcriptions were corrected. The Arabic transcripts were checked by an Arabic-speaking colleague in an analogous manner. After checking and correction, the Arabic transcripts were then translated into English by a certified translator, and the translated transcripts further checked to ensure precision of terminology within the context of the interviews. Due to the lack of medical translation expertise on the part of the translator, no transcripts were returned to the translator for correction. Instead, I and my Arabic-speaking colleague worked to revise the translated transcripts to allow analysis to be conducted in English for the full transcript corpus.

Nevertheless, the very act of translation, no matter how careful, is likely to weaken the existential sense of the participants' views, although the researcher identified no Arabic words or statements that could not be translated into English to some extent. This issue was also mitigated by continuous checking of the text throughout the analysis process to determine the original sense of the translated texts.

6.9 Participants

After having discussed the research methods and before presenting the results, demographic information related to the participants is presented in this section.

6.9.1 Nurses' demographic information

A total of twenty-one nurses participated in the study, of whom eleven worked in Hospital A and ten worked in Hospital B. They all held one of the following qualifications:

- A Diploma in General Nursing, which requires two years of study of general nursing after high school.
- A Higher Diploma in General Nursing, which involves three years of study of general nursing after high school.
- A Bachelor's degree in General Nursing, which requires four years of study of general nursing after high school; this also includes a course on, and brief training in, mental health nursing.

In addition, one nurse also had a Mental Health Nursing specialty, which involved intensive training in mental health nursing at the end of her Bachelor of Nursing degree. Full details about the nurses' demographic details are given in Table 6.7, while Appendix 4 includes further demographic data.

6.9.2 Demographic details of women with psychosis

Twenty-one women with psychosis participated in the research, seven from Hospital A and 14 from Hospital B. The demographic data listed below were elicited from the women themselves, some of whom claimed they did not know some of their information. One interesting fact that emerged was the high ratio of single and divorced women to married women. Table 6.8 offers some demographic information on this cohort, while Appendix 4 gives further demographic data on the women with psychosis who were interviewed.

Table 6.7: Nurses' demographics

Number (N)	Name (Pseudonyms)	Age (years)	Hospital (A/B)	MH unit	Arabic/Non-Arabic	MHN Experience (years)	Qualifications	MHN Training (Y/N) (19 Nurses)			
								MH Principles	Mental Illness and Symptoms	Psycho-Social Interventions	Medications
N1	Sarah	48	B	Inpatient	Non-Arabic	18	Dip., GN	Y	Y	Y	Y
N2	Sophia	59	B	Inpatient	Non-Arabic	30	Bachelor, MHN	Y	Y	Y	Y
N3	Rachel	40	B	Inpatient	Non-Arabic	13	Bachelor, GN	Y	Y	Y	Y
N4	Samantha	41	B	OPD	Non-Arabic	15	Dip., GN	Y	Y	Y	Y
N5	Anna	46	B	OPD	Non-Arabic	6	Bachelor, GN	Y	Y	Y	Y
N6	Daisy	32	B	OPD	Non-Arabic	6 months	Bachelor, GN	Y	N	N	N
N7	Caroline	30	B	OPD	Non-Arabic	6	Bachelor, GN	Y	Y	Y	Y
N8	Catherine	53	B	Inpatient	Non-Arabic	17	Dip., GN	N	N	N	Y
N9	Maddison	58	B	Inpatient	Non-Arabic	31	Bachelor, GN	Y	Y	Y	Y
N10	Saleha	27	A	Inpatient	Arabic	7 months	Bachelor, GN	Y	Y	N	Y
N11	Afra	32	A	Inpatient	Arabic	1	Dip., GN	Y	Y	N	Y
N12	Hafsa	30	A	Inpatient	Arabic	8	Dip., GN	Y	Y	Y	Y
N13	Madeeha	28	A	Inpatient	Arabic	1	Bachelors, GN	Y	Y	Y	Y
N14	Fadwah	28	A	Inpatient	Arabic	3	Dip., GN	Y	Y	N	Y
N15	Ahd	26	A	Inpatient	Arabic	2.5	High Dip., GN	Y	Y	N	Y
N16	Majidah	40	A	OPD	Arabic	8	High Dip., GN	N	N	N	N
N17	Malak	30	A	OPD	Arabic	8	Dip., GN	N	N	N	N
N18	Sabah	27	A	Inpatient	Arabic	6	Dip., GN	Y	Y	Y	Y
N19	Rebeca	45	B	Inpatient	Non-Arabic	20	Dip., GN	Y	Y	Y	Y
N20	Manahel	27	A	Inpatient	Arabic	5	Dip., GN	Y	Y	N	Y
N21	Rabab	29	A	Inpatient	Arabic	3	High Dip., GN	Y	Y	Y	Y

Key: MH: Mental Health, MHN: Mental Health Nursing, N: Nurse, OPD: Outpatient Department, Dip: Diploma, GN: General Nursing, Y: Yes, N: No

Table 6.8: Women with psychosis biographies

Number (WWP)	Name (Pseudonyms)	Age (years)	Hospital (A/B)	MH unit	Marital Status	Children (Y/N)	Education level	Job (Y/N)	First Episode (Age)	Nationality
WWP1	Safiya	29	B	Inpatient	Married	Y	Intermediate	N	17	Saudi
WWP2	Zahra	40	B	OPD	Married	Y	Secondary	N	17	Saudi
WWP3	Jana	42	B	Inpatient	Single	N	Secondary	Y	20	Saudi
WWP4	Hala	50	B	OPD	Single	N	University	N	25	Saudi
WWP5	Joud	21	B	OPD	Single	N	Secondary	N	17	Saudi
WWP6	Lama	37	B	OPD	Divorced	Y	Secondary	N	20	Saudi
WWP7	Nadia	33	B	OPD	Single	N	Primary	N	18	Saudi
WWP8	Abeer	27	B	OPD	Single	N	University	N	20	Saudi
WWP9	Karima	40	B	OPD	Married	Y	Secondary	N	17	Saudi
WWP10	Maha	40	B	OPD	Married	N	Primary	N	15	Saudi
WWP11	Sahar	47	B	OPD	Married	Y	Secondary	N	41	Saudi
WWP12	Afaf	26	B	OPD	Single	N	Secondary	N	16	Saudi
WWP13	Nahla	25	B	OPD	Single	N	Intermediate	N	17	Saudi
WWP14	Hamida	30	A	Inpatient	Divorced	Y	Illiterate	N	20	Saudi
WWP15	Alya	50	A	Inpatient	Married	Y	Intermediate	N	15	Saudi
WWP16	Halima	48	A	Inpatient	Divorced	Y	Secondary	N	26	Saudi
WWP17	Eliana	52	A	Inpatient	Divorced	Y	University	N	25	Egyptian
WWP18	Jumana	42	A	Inpatient	Married	Y	Intermediate	N	13	Saudi
WWP19	Dalia	56	A	Inpatient	Divorced	Y	Primary	N	20	Saudi
WWP20	Salma	35	B	OPD	Widowed	Y	University	Y	24	Saudi
WWP21	Najat	31	A	Inpatient	Single	N	University	27	27	Saudi

Key: WWP: Women with Psychosis, OPD: Outpatient Department, Y: Yes, N: No

6.10 Summary

This chapter has presented the methods used in this research, beginning with an overview of the context of the study across two hospitals. The selection, recruitment, and interview procedures applied to participants were highlighted in this chapter and the challenges arising in the interviews were included. Analysis of the texts using van Manen's (2016) schema was stressed throughout, with some examples of analysis. Ethical considerations were also discussed, together with some challenges faced in applying these considerations. The rigour of this phenomenological research was then discussed, followed by an outline of the ways in which the trustworthiness of parts of this research was promoted. The final part of this chapter offered a brief overview of participants' demographic details, with supporting tables.

Within the interviews with 21 nurses and 21 women with psychosis, van Manen's (2016) hermeneutic analysis was applied: the four analysis chapters present analyses of both cohorts' interviews. The next chapter presents the researcher's experience of analysing this research to clarify the ways in which the processes inherent in analysing the interviews shaped the findings.

Chapter Seven: Understanding the Impact of Researcher

Position on the Analysis of the Findings

7.1 Introduction

In this chapter, I reflect on my position as researcher in relation to the findings of this study. The rationale for undertaking this reflection is to offer clear insights into my experience while conducting this study. The engagement of the researcher during analysis of the data is an important hermeneutic and phenomenological process, and then the report moves to the research findings. This chapter merges and matches these stages, leading back from the discussion to the initial reasons for the research. As a researcher, I had experiences and thoughts to analyse this research using a phenomenological approach and I applied the methodology based on my position within the research. This position included the challenges of analysing the interviews and writing a meaningful account of the analysis and the findings. These challenges resulted in me experiencing several ups and downs, as I developed my self-confidence as a novice researcher in this field. However, I have overcome these challenges by adopting multiple strategies to proceed with the analysis. This chapter concludes with a section which maps the focus and content of the following four chapters in which the findings are reported.

7.2 Understanding the researcher's position with respect to analysing the interviews

In the researcher reflection in the previous chapter, I discussed my experience of recruiting and interviewing the thirteen women with psychosis and twenty-one nurses using audio

recorded interviews. There was a considerable variation in the length of the interviews, and this was an additional challenge to how to undertake the phenomenological analysis of the resulting manuscripts and whether these differences would affect the quality of the research. I was unsure if I needed to exclude these short interviews or include them while I was starting the preliminary analysis in the period of collecting data. However, my supervisor suggested that, because I had conducted numerous interviews, the short ones were not an issue, as others which were longer and richer in detail were available. Nevertheless, each participant's experience is unique and important, and worth gathering, even in situations where only a limited amount of content was provided. This mirrors a central feature of qualitative research, which is that each experience, regardless of interview duration, is both illustrative and unique. That was a source of relief for me as a researcher, as a review of each interview suggested that, despite some of them being relatively short in duration, the content in each case offered new insights into participants' experiences in an impressive manner.

The quality of qualitative data derived from interviews of participants who may have difficulties providing detailed accounts of their experiences, such as the women with psychosis and nurses in this research, has been previously explored in the literature (Kirkevold & Bergland, 2007). In order to manage this challenge and to achieve a rich repository of overall material, a researcher must plan for variation in the interviews and data collection processes (West, Bondy, & Hutchinson, 1991). This approach provided for participants who had a range of skills and abilities (Kirkevold & Bergland, 2007), such as some women with psychosis in this research who could only be interviewed for a short time, to still make a valuable contribution to the research as a whole. As Kirkevold and Bergland (2007) indicate, adjustment when interviewing participants seeks to ensure that an adequate picture can be developed of the experiences and perceptions of persons, by accommodating their varying resources and levels of articulation. Furthermore, Kirkevold and Bergland

(2007) suggest that thin descriptions of certain aspects of information provided by some participants are limited value when viewed in isolation, may nevertheless yield, corroborate, or qualify other insights with the accounts of more articulate participants. Therefore, the recorded interviews with women with psychosis and the nurses collectively made a vital contribution and added some important insights into the experience of psychosis among women in the KSA and the experience of nurses providing care to women. However, the variations of accounts of participants remained as a challenge for me in styling the analysis. This issue is discussed in the following section.

7.3 Understanding the researcher's position regarding the writing style of the analysis

After reconciling the challenges of adjusting the interviews to match the needs of the participants and the conditions imposed by the organisations, I was able to begin examination of the data and identify preliminary themes in a relatively smooth manner. However, the process of determining how to style my writing to best discuss the findings raised several issues that needed to be considered during the writing of the analysis chapters.

In planning I imagined there would be an initial level of analysis based on the descriptions using the participant's words, predominantly driven by the participants' voices. In keeping with van Manen's (2016) methods, a second level of analysis was anticipated to involve conceptual discussion and to feature more of my voice and reflections as the researcher.

These levels can be identified in the analysis used in presenting the findings and discussion separately in the chapters. However, this style was a challenge overall, as I needed to integrate these elements and divide the chapters according to the major themes identified.

This solution was to tread a middle pathway between the imagined levels one and two of

analysis. This integration influenced the style of writing and presenting the results, allowing me to integrate participants' voices and descriptions with more in-depth discussion by investigating the literature relevant to voices, then offering reflection in a hermeneutical style immediately afterwards. This was the style used to present all the findings, and this was a conscious choice. My influence as researcher was to use the active voice in presenting the findings with the discussion in a reflexive phenomenological manner. However, the selection of the style of analytic writing which followed my perceptions and thoughts about the interviews and emerging data, created a struggle for me to be confident as a researcher in this field. The milestones in establishing and building my self-confidence to do this research are highlighted in the following section.

7.4 Self-confidence as a researcher

The phenomenological approach was a new method for me as a researcher, and I found it challenging to gain insights into the experiences of women with psychosis in KSA and nurses caring for them. As a novice, my self-confidence regarding the depth of this research inquiry was tentative. As data saturation began to build across the interviews, I had to consider whether to proceed with further recruitment and interviews of participants and began to consider how to style the emergent and resulting phenomenological analysis. The way these issues were addressed is discussed in the previous sections, and finding these solutions allowed my self-confidence to develop gradually over the time, based on my slow but steady success in data collection and analysis.

Other challenges to my self-confidence as a novice researcher performing phenomenological analysis arose during the analysis in cases where I found my viewpoint becoming more critical, especially considering some nurses' care. My work as a mental health nursing educator affected my responses, resulting in my adopting a critical educator stance. Initially,

on writing the first versions of the analysis, the essence of participants' experiences was not clear due to the criticality displayed towards their accounts. This did not produce an adequate level of reflective writing, and further undermined my self-confidence to proceed. Therefore, I thought about setting imaginative red flags during the writing while establishing a position of mindfulness to overcome this trait in my writing. When I found myself critiquing nurses' practice as an educator, I stepped back and took a moment to perceive the red flags raised. Then I returned to reflect on the experiences of nurses and women as described, without any judgments or assumptions, as this process of detached observation better supported me in this study.

Despite the improvement to my reflective writing, another issue adversely impacted my self-confidence regarding the analysis, which was my ability to write effectively in the chosen style, integrating findings, discussion, and reflection. Some issues with clarity were prominent in the early versions of the analysis, and this created a potential *cloudiness* in the reporting of the participants' essential experiences. My supervisors offered clear critiques of this lack of clarity regarding what the analysis meant. At some points, this difficulty in writing phenomenologically created significant issues, decreasing my confidence in my ability to continue the writing, and rewriting. Luckily, I realised that inexperience and inconsistency in my phenomenological writing style were the main issues and needed to be addressed to improve my writing. My supervisors offered guidance in modifying my work, suggesting that themes should be introduced first, along with the explanation of how they related to van Manen's (2014) methods. Next, the main concepts, operational definitions, and aspects related to the themes were determined, followed by an introduction to the participant's voices, the voices themselves, and a reflexive discussion emphasising those voices. The following step was to highlight how participants' experiences might be addressed through the lens of my practice. Summative comments were also offered at the end of each

theme to reconcile all the available analytical work on the relevant phenomena. Balancing all these aspects within my writing was my initial aim, and thankfully, my supervisors also offered help by showing me how to work in this style, as well as by coaching me through the writing. Achieving a satisfactory format for some sections developed my self-confidence enormously, allowing me to proceed with the rest of the writing.

The final stage where I developed my self-confidence in terms of writing phenomenologically was writing and rewriting. This process, accompanied by micro-revisions of the structure of the writing and the meaning behind it, allowed me to be honest and open to modifications, as well as permitting discussion with my supervisors of any issues raised during the writing. This has developed my self-confidence as a researcher significantly.

When I conduct phenomenological research again, I will be more mindful about moving between a phenomenological and critical lens, as well as striving to avoid inconsistency in my writing style. This mindful approach to honest and meticulous writing and rewriting will help avoid many hurdles that undermine the analysis at a later stage in this case, helping to avoid wasting my time and effort, and preventing the experience of low self-confidence that adversely impacted my motivation to proceed with this research in the earlier stages.

Despite my wavering motivation, however, and despite the challenges cited in this chapter and the previous one in terms of data collection and analysis, the transparency that emerged from examining the experiences of women with psychosis together with those of nursing staff increased my confidence and allowed me to pursue my research aim, which was to reveal the essence of these unique experiences. These experiences have been mapped out in four analysis chapters, as explained in the next section.

7.5 Mapping of the analysis chapters

The aim of the following four chapters is to illuminate the analysis of nurses' experiences caring for women with psychosis and the experiences of women with psychosis in KSA. The chapter format allows hermeneutic phenomenology to be presented by integrating findings, discussion, and reflection, as discussed earlier. Moreover, there is a horizontal integration of van Manen's (2014) existentials in each analysis chapter to identify the themes which emerged from the participants' accounts. This horizontal integration is maintained with the vertical integration of the analysis with the literature presented in the early chapters.

It was the conscious decision of the researcher to present the nurses' accounts in three chapters (Eight, Nine, and Ten), while the women's accounts are presented in a single chapter (Eleven). Moreover, the nurses' analysis is relatively longer than that of the women. It was considered better for the integrity of the findings that the nurses' findings are presented in multiple chapters and the women's findings in one chapter. Furthermore, the resulting weight of the thematic analysis of nurses' accounts derived from the identification of more themes; therefore, more chapters were required to deal with these themes. In the case of the analysis of the women's findings, there is less breadth of themes, and it was easier to manage them in one chapter. The possible reason for the nurses' themes being more extensive than those of the women was the nature of their views in relation to the research aim to explore their knowledge and interventions when providing care. Therefore, the nurses' perspectives captured more information.

7.5.1 An analysis of nurses' experiences of caring for women with psychosis

Chapters Eight, Nine and Ten offer an analysis of nurses' accounts, addressing the research aim with respect to the nurses' cohort: to examine the experiences of nurses regarding care

provision for women with psychosis in KSA. Following van Manen's (2016) phenomenological method, the nurses' experiences of caring for women with psychosis are interpreted in a manner which identifies three major themes, based on three main existentials: lived space, lived body, lived self-other. Van Manen's (2014) remaining three existentials, lived time, lived thing, and lived cyborg, are also used to identify certain themes or sub-themes; however, these are used less frequently and are interspersed with the main existentials.

Each of the three main themes identified constitutes a chapter of this research (see Table 7.1). These are *Nurses' perspectives on working in mental health facilities in KSA: lived space* (Chapter Eight); *Nurses' experiences of providing care to women with psychosis in KSA: understandings and emotions* (Chapter Nine); and *Nurses' experiences of care for KSA's women with psychosis: lived self-other* (Chapter Ten). Each major theme is also discussed in terms of its themes and/or sub-themes.

Table 7.1: The three overarching themes of mental health nurses' care experiences for women with psychosis in KSA and the chapter where they are presented

Mental Health Nursing Care for Women with Psychosis in KSA	
Chapter Eight	Nurses' perspectives on working in mental health facilities in KSA: lived space.
Chapter Nine	Nurses' experiences of providing care to women with psychosis in KSA: understandings and emotions.
Chapter Ten	Nurses' experiences of care for KSA's women with psychosis: lived self-other.

7.5.2 An analysis of women's lived experiences of psychosis

To analyse the lived experiences of women with psychosis in KSA in greater depth, Chapter Eleven is similarly structured using van Manen's (2016) phenomenological method. To achieve this, the analysis strategy explored the experiences of women with psychosis in terms of the following aim: to examine the experience of women living with psychosis and to understand women's experiences of nursing care within mental health facilities in KSA. The

transcripts of recorded interviews, field notes, and the women's own texts (drawings and notes) were analysed in keeping with van Manen's (2014) six lifeworld existentials, which were used as a frame for analysis. Van Manen's (2014) vocative method of analysing textual forms was used to analyse the drawings and notes during the pre-analysis stage, to reveal the embedded meaning of the texts before the hermeneutic phenomenological writing began. Three main themes were identified and informed by van Manen's (2014) views, as represented in Table 7.2: (1) *Women in KSA and their lived experiences of first-episode psychosis*; (2) *KSA women's experiences of living with psychosis after admission to or on follow-up from a mental health facility*; and (3) *KSA women's experiences of living with psychosis in the community after discharge from a mental health facility*. Every major theme identified in analysing the women's texts also had sub-themes.

Table 7.2: Major themes and sub-themes identified for women with experience of psychosis presented in Chapter Eleven

Experiences of Living with Psychosis and Being Cared for Among KSA Women	
Theme 1	Women in KSA: their lived experiences of first-episode psychosis.
Theme 2	KSA women's experiences of living with psychosis after admission to or follow-up from a mental health facility.
Theme 3	KSA women's experiences of living with psychosis in the community after discharge from a mental health facility.

7.6 Summary

In this chapter my experiences during and thoughts on undertaking research about women with psychosis and nurses in two KSA mental health facilities were highlighted. The aspects discussed in this chapter should aid understanding of my position as a researcher in the analysis presented in the following chapters. These aspects included my position regarding analysing short accounts and styling hermeneutic phenomenological writing. These major challenges influenced me to establish and build my self-confidence as a novice in this

phenomenological field. By recognising the challenges and dedicating myself to overcoming them, a satisfactory improvement was created which promoted my confidence and allowed me to proceed with the analysis.

The final part of this chapter offered mapping of the analysis chapters. In the next chapter, the first chapter of analysis, an attempt is made to shed light on nurses' perspectives on providing care for women with psychosis in relation to the spaces in KSA mental health facilities.

Chapter Eight: Nurses' Perspectives on Working in Mental Health Facilities in KSA - Lived Space

8.1 Introduction: Uncovering mental health lived spaces in KSA

This chapter focuses on the first major theme identified from nurses' views on their experiences of caring for women with psychosis in KSA mental health facilities, and their views about their experiences with mental health spaces as part of such care. The fundamental interpretation of all views was based on van Manen's (2014) lifeworld existential of lived space. This life world existential enabled the researcher's exploration of nurses' perspectives on the impact of space in terms of mental health facilities on their care for women with psychosis. An observable clustering of views of nurses in which lived space was identified, generated the major theme: *Nurses' perspectives on working in mental health facilities in KSA*. Other existentials influenced lived space, and these were also used to analyse the nurses' perspectives and supported the use of lived space as the main framework. For example, the nurses at Hospital A highlighted rules preventing them bringing food or preparing hot food on the wards; this was part of the lived space in the ward space, but to understand how nurses lived with these rules, van Manen's (2014) lived things existential was also used. These nurses also described their exhaustion and loss of motivation caused by hunger which impacted their experience of offering care in such spaces; these feelings were further explored using the lived body (van Manen, 2014).

The hermeneutic analysis using van Manen's (2014) existentials was integrated with the findings emerging from the nurses' responses, and with discussions and reflections related to the major theme of this chapter. Within this major theme, the nurses' views are clustered into

themes, as shown in Table 8.1: *Lived experience of giving care in inpatient spaces; the need for healing spaces; nurses' lived spaces in outpatient settings.*

Table 8.1: The major theme of experiencing mental health nursing care in KSA mental health facilities and the three themes

Major Theme: Nurses' Perspectives on Working in Mental Health Facilities in KSA	
Theme 1	The Lived experience of giving care in inpatient spaces.
Theme 2	The need for healing spaces.
Theme 3	Nurses' lived spaces in outpatient settings.

Before reporting the nurses' perspectives which identified this theme, it is worth noting that there has been no previous research in the context of the KSA regarding the impact of mental health physical spaces on nursing care experiences. This chapter therefore seeks to report what it was like for the nurses who participated in this study to experience caring for women with psychosis in KSA based mental health spaces.

8.2 Hospitals A and B: A general overview

Interviews of participants were conducted in two KSA hospitals, known in this study as Hospital A and Hospital B (see Chapter Six). Inpatient mental health facilities throughout KSA, as noted by Alanazi (2020), are segregated by gender into male and female wards, and all consumers are cared for by nurses of the same gender. Wards and activity spaces in the KSA operate fully independently of one another, creating gendered-based units where female-only nurses care for women in dedicated mental health facilities (Alanazi, 2020). The reason for this segregation is primarily cultural and religious, with women separated from men in all places outside their family context (Gazzaz, 2009). Based on the researcher's knowledge of Hospital A, the entire mental health team involved in the treatment of women consists exclusively of females, while men are treated solely by male staff.

Hospital A's female inpatient wards are dispersed across three floors in a single, relatively new, building. To the best of the researcher's knowledge of the female inpatient wards in Hospital A, the first floor is the long-stay ward, while the short-stay ward is located on the second floor and the third floor provides addiction services. The design and structure of the short-stay ward on the second floor is identical to that of the long-stay facility. The building is not close to other clinics nor to the Emergency Department, and the resulting isolation of the buildings might be viewed as a form of, or result of, stigma towards mental illness as experienced by the women on these wards, which may create further impediments to their treatment and recovery.

Hospital B's mental health department was opened in the 1980s (Alhamad et al., 2004), and the inpatient unit is located next to the mental health OPDs. The inpatient provisions consist of separate wards for female and male consumers, one for each, with 11 mental health beds per ward (Al-Sughayir, 2016).

All mental health wards were locked. Locked wards are a feature of the mental inpatient facilities in both hospitals (Al-Subaie, Marwa, Hawari, & Abdul-Rahim, 1996; Al-Sughayir, 2016). The researcher observed that female security guards were situated at the entrances and exits to the wards in Hospital A to oversee the meetings of those visiting the hospital and the female inpatients. Such visits are possible with permission from the mental health team. In male wards, only male guards are present because of the segregation between the genders discussed earlier. In addition to guards being located outside the wards, there are also some based inside the wards. Their roles include managing the doors and keeping them secure, along with verifying who enters and leaves the wards. In contrast, in Hospital B, no security guards are used, and the nurses have responsibility for opening the doors of the wards to visitors. However, the whole inpatient unit, which consists of two separate inpatient wards

for male and female consumers, is locked with electronically secured doors, with one secure door outside the unit and similar doors to each ward.

Further observations were made by the researcher about the windows in the living spaces in both hospitals. The living space in Hospital B has no windows, and while there are windows in Hospital A, they are placed so high up the wall that they prevent consumers from seeing outside. These windows are also locked and never opened, so no fresh air enters the area.

Access to fresh air and exposure to sunlight is possible in the wards in Hospital A by means of access to a courtyard, and many chairs are placed in this area; however, there are no green spaces. Many rooms in Hospital A's ward lead off the hall, including a nurses' lounge, which is locked electronically. There are no kettles or microwaves in the nurses' lounge, despite it being locked, as the Security Department does not allow these items to be brought into the room, putatively to safeguard nurses from high-risk consumers. The rationale for this decision is that aggressive consumers might push to open the lounge door while a nurse was trying to close it, and if they entered and found kettles with hot water to hand, they might pour this on others, or, similarly, if there was any hot food in the microwave, they might throw it at others.

This background to both hospital spaces is linked to the relevant participants' experiences of space, and as discussed in the following sections, the nurses tended to highlight how their lived experiences of hospital spaces impacted their offering of care to KSA women with psychosis. Chapter Eleven also discusses experiences of hospital spaces, but there, the focus is on the women with psychosis and their experiences of such spaces as part of the psychotic experience.

8.3 Theme 1: Lived experience of giving care in inpatient spaces

The theme of lived inpatient spaces was identified within the major theme *nurses' perspectives on working in mental health facilities in KSA*. Related to lived space, van Manen's (2014) lived things and lived body existentials also provided insights into the nurses' lived experiences of the inpatient ward space. For example, the lived space for the nurses was impacted by Hospital A's rules, which limited their access to food and caused the nurses to become exhausted during the process of providing care. The nurses' views of their experiences of providing care in KSA mental health facilities were determined by the impact of the design of the mental health inpatient ward on the care experience of those nurses, as well as by their experiences of mental healthcare ward facilities in use.

Several nurses in this research viewed their experience of caring for women with psychosis as being strongly impacted by the design of the inpatient ward. Various nurses revealed their satisfaction with the design of the new building, with some concerns around safety issues and restrictive practice spaces.

Several nurses working in Hospital A indicated they were satisfied with their working experience generally due to the improved quality of the new building. For example, Madeeha stated, 'The environment here is good. There is a hall [an open space inside the ward], and the rooms are comfortable' (p. 2, lines 65-66), while Fadwah pointed out that 'This building is new and luxurious, and it has everything' (p. 2, line 63). Sabah also reflected on the improvements offered by the new ward: 'What distinguishes this ward is [that it is] new and recently opened. The previous one had cockroaches' (p. 2, lines 63-64).

These nurses expressed their satisfaction at working in a new, more spacious ward. Sabah's emphasis was on the benefit of the newly opened building compared with the old one: she discussed problems with the older building, including insect infestations, reflecting the

concept that some concerns regarding sanitary needs that had previously been an issue had been addressed with the opening of the new building.

The physical environment as a part of the nursing care experience for consumers with mental illness has been explored by O'Brien and Cole (2004), who highlighted the importance of the design and environmental features in mental health units, arguing these must provide security, privacy, comfort, and ample space in order to create a suitable therapeutic milieu to help nurses care for consumers. The increased comfort of nurses such as Madeeha while providing care for women with psychosis in the improved space is therefore of significant importance.

In contrast, Rachel, from Hospital B, mentioned the specific difficulties she had in providing care due to issues arising from the ward design there, and the lack of wastewater disposal and drainage in the floors in the toilets. She stated:

The disablers [to providing care] in the environment...there are a few disablers [that make the environment] sometimes not suitable [for consumers]. Our toilets need to change. We do not have drainage here, so the environment is not suitable for our [consumers]. You know, our [consumers with] psychosis and [those who have] OCD [obsessive compulsive disorders], they put [much] water [around] in the toilets, and there is no [floor] drainage here, so the environment is not suitable... Even though we have [so many] things good here... this thing [the lack of drainage] is not good over here. (p. 4, lines 144-148)

Rachel's perspective on the significance of the toilets having no drainage in the floor reflects her concerns about a safety issue, as this can create slip hazards in the toilet area, which is likely to impede the nurses' care of women with psychosis in her view. This issue may compromise the safety of both consumers and workers, and it is a fundamental principle in mental health inpatient wards that staff and consumers should be kept safe throughout by means of the incorporation of features to prevent slipping, as well as the provision of adequate drainage in wet areas such as toilets and showers (Australasian Health Infrastructure

Alliance, 2016). Where such safety issues arise, this may impact nursing care experiences, as nurses like Rachel who are caring for women with psychosis may experience conflict between attempting to look after the women in their charge while striving to maintain their own balance and safety.

The other main issue raised by some nurses about the care they provide to women in these hospital spaces was related to the use of restrictive practices. Restrictive practices such as seclusion and restraint are often used in healthcare settings such as mental health inpatient wards to manage consumers who are deemed to display aggression or violence (Muir-Cochrane, O'Kane, & Oster, 2018). One in six consumers with psychosis is exposed to seclusion or restraint (Steinert, Bergbauer, Schmid, & Gebhardt, 2007). This high proportion of consumers being subjected to such practices suggests that restrictive practices continue to be accepted for use in mental health care by staff (Muir-Cochrane et al., 2018), despite their use having been criticised for many reasons. In particular, many consumers have highlighted the negative impacts of such treatment, such as fear, anger, shame, overwhelming feelings of being abandoned, and other traumatic responses (Chan, LeBel, & Webber, 2012). Restrictive practices may therefore have multiple negative impacts on the course of psychosis (Meyer, Taiminen, Vuori, Äijälä, & Helenius, 1999), as well as damaging the emergence of therapeutic relationships between consumers and health professionals (Theodoridou, Schlatter, Ajdacic, Rössler, & Jäger, 2012). Such damage may be further explained by the fact that restrictive practices are entirely contrary to the principles of person-centred care (Muir-Cochrane et al., 2018), and there is no scientific evidence for the positive therapeutic impacts of these practices as treatment interventions (Klein, 2011). The use of such practices also runs counter to the restrictive practice reduction policies promoted by the WHO (2005) and the findings of the current literature on mental health settings (Brophy, Roper, Hamilton,

Tellez, & McSherry, 2016a, 2016b; Goulet, Larue, & Dumais, 2017; Goulet, Larue, & Lemieux, 2018; Mangaoil, Cleverley, & Peter, 2018).

In relation to the seclusion rooms in Hospital B's wards, Sophia viewed the presence of padded seclusion rooms as an improvement in the inpatient ward:

Now we have [a] padded room. [It is a] seclusion room, [and if] we have a shortage of staff, when we have a very aggressive [consumer], we [have otherwise had to] call for help from male staff [on the ward to restrain women]. (p. 3, lines 85-86)

Catherine, from the same ward, highlighted the nurses' perceptions of the need for more seclusion rooms: 'Here at the mental health unit, we have one seclusion room, and that is not enough...we told the department [to increase the number of seclusion rooms]' (p. 2, lines 52-53). These padded rooms are considered necessary by Sophia and Catherine, with Sophia's positive view of the seclusion room being reflected in her satisfaction with the presence of this room, which she justified in two ways: the first being that, when consumers display aggressive traits, the staff would otherwise have to ask for help from male nurses from the male ward, while the second referred to the limited number of nursing staff on the ward. Catherine's positive view of these rooms is implicit in her recommendation for the inclusion of more seclusion rooms. Sophia and Catherine's experiences appear to create a vicious cycle of acceptance and approval thus reinforcing these unsound methods.

Sophia's framing of situations of aggressiveness, where staff feel they must ask for the help of male nurses from the male ward, might further negatively impact the care provided to women. In KSA culture, the segregation of males and females, especially in mental health settings, is mandatory; having to ask for help from male nurses to care for these women may make the nurses' experience of care highly uncomfortable, and the women consumers are unlikely to feel comfortable receiving care from male nurses. This perspective helps to explain Sophia's positive perceptions of the presence of a seclusion room.

The other reason Sophia offered in support of the use of seclusion rooms was the issues caused by the limited number of nursing staff on the ward, and such nursing shortages have been shown to tend to lead to greater use of seclusion practices in other contexts. Khalil, Al Ghamdi, and Al Malki (2017) explored nurses' increased use of seclusion and restraints in a facility, focusing on the external factors contributing to this, and one factor identified was inadequate nurse-to-consumer ratios. The inadequacy of staffing made nurses feel stressed and overwhelmed while providing care due to a shortage of support, causing them to tend to use restrictive practices more frequently, as these were seen as easy approaches to managing consumers' aggression (Khalil et al., 2017). During the interviews for this research, the nurses at Hospital B were frequently rushed away by the head nurse or charge nurse before the natural end of those interviews, being pressured by an overwhelming lack of staff to return to their assigned consumers. This observation supports the nurses' reported experiences of insufficient staffing levels, suggesting that nursing care is likely to be impacted by staffing issues. The suggestion of nurses in Hospital B, such as Catherine, that more seclusion rooms are needed, may simply reflect their desire for a reduction in workload. Staff shortages or inadequate staffing for current consumer levels is discussed in more detail in the next chapter, which focuses on the shortage of nursing staff across both hospitals as a common issue.

It can also be assumed that the satisfaction of nurses regarding the potential for and adoption of restrictive practices reflects a focus on physical care, as this is the only aspect facilitated by these practices. This suggests that a service-based recovery approach (Schrunk & Slade, 2007) is used by these nurses in providing care, which means that the women in care are not empowered or encouraged to help themselves or to exercise self-control. This gap in these nurses' provision of care may hinder women from recovering.

Alongside the impact of inpatient ward design on their experiences of providing nursing care for women with psychosis, several nurses discussed the limited facilities available for nurses as another factor which negatively affected their experiences of providing care. Manahel noted the lack of support facilities such as food and childcare facilities at Hospital A:

We have no services here, [such as] a café or a nursery...even after we asked [the administration department] for them. The female security workers [inside the wards] and we are dying of hunger, as we do not have a restaurant for employees like other hospitals. It is not permitted to have a kettle for coffee and tea; security [staff] took it. We cannot drink coffee here, only [if] one of us brings [a] thermos from her house, and there is no food here. There is no nursery for our children, and my house is far away from the hospital. I eat once before coming here and stay all day with no food until I go home. There is no coffee, no breakfast or lunch. (p. 2, lines 76-82)

Manahel expressed her view that the lack of childcare facilities prevents nurses taking care of themselves and providing better care for consumers. The lack of childcare facilities also compounds nurses' conflicting feelings regarding their family responsibilities; this need has been addressed in western hospitals since the 1980s, when hospitals with on-site childcare were generally introduced (Polito, 1985). Polito (1985) posited that the reason for this increase in childcare was the nursing shortages in those countries caused by nurses staying at home once they had childcare responsibilities; therefore, to entice trained nurses to continue to work or to return to work, many hospitals established on-site childcare centres. As KSA is an Islamic society, in which a woman's primary work is seen as being to take care of her family and children, commitments to the nursing profession are even more complex, as women are pressured to prioritise the needs of their children (Goodhue, 2012). Although females are a majority in the field of nursing (Eriksen & Einarsen, 2004), they are also expected to take on the majority of childrearing responsibilities as they start their families, and the lack of childcare in Hospital A creates a significant problem in relation to these

nurses' experience of offering care to women with psychosis. Nurses' family responsibilities and needs may overwhelm them even as they attempt to provide care.

Manahel also expressed concern about the lack of accessibility of food in Hospital A; this opinion was supported by other nurses, such as Sabah, who worked in the long-stay inpatient ward: 'As for the environment here, nothing is available in the nursing room, and we cannot [store] or bring anything [to eat or drink]' (p. 2, lines 62-63). She expressed her concern about the struggle to access food while at work: 'We do not have any grocery or café and it is not permitted to bring food with you inside... The food quality here is...bad. We can bring food from our house, but no microwave is permitted here' (p. 3, lines 88-90). Ahd also described nurses' concerns regarding food and catering, along with the consequences of this for the nursing care experience: 'Sometimes I come at 6 am and work till 3 pm and I eat nothing during this period.... In this department, I cannot have breakfast. The food provided by the canteen service is not good'. (p2, lines 73-78). She also noted that the lack of facilities contributed to her feeling exhausted, as well as showing that she was not respected as a nurse:

We waste much time in asking for such [food] services or just starve.
Therefore, I get back to my home incredibly exhausted, which is not good.
Nurses do not get any respect; I feel as if we are imprisoned. We work 8
hours a day and we cannot eat, so I do not blame my colleagues for their
absence or sick leave because of the pressure we suffer from. (p. 2, lines
81-85)

Many nurses emphasised this experience of a lack of food facilities. Nurses were prevented from heating their food or preparing hot drinks based on Security Department concerns and rules, according to Manahel. The researcher's observations, as discussed earlier, confirmed that the Security Department perspective was that hot food or drinks might threaten the safety of the women in the wards, based on the assumption that women displaying aggression might throw food or spill drinks on others. Ahd emphasised that, at times, this gap in food facilities led to the nurses experiencing sickness and taking additional leave. Horton Dias and Dawson

(2020) similarly suggested that hospital and shift work nurses experience many dietary problems that impact their health and may be worsened by factors such as hospital food environments being unhealthy, particularly during certain shifts, which increases the risk of illness in nurses on shift work.

At the point when the female nurses in Hospital A were interviewed for this research, prior to 2018, they could not even drive to obtain food from restaurants during their breaks, as women were not permitted to drive in KSA at that stage. They were *stuck* in the ward and unable to obtain food, while bringing food from home was problematic due to them being unable to heat any food on the wards. This was emphasised by Sabah, who referred to double standards preventing nurses from accessing food. Many nurses did indeed present as exhausted and lacking in energy during the interview, which could be attributable to their inability to access food quickly and in a flexible manner. This was further reflected by Ahd's statement that they were starving, which highlights the importance of facilitating nurses' self-care by creating access to healthy food among staff: nurses need to look after themselves to have the energy to care for consumers effectively.

The nurses' experiences of providing care to KSA women with psychosis in inpatient wards were explored through van Manen (2014) lifeworld existential of lived space. The lived experiences of nurses' provision of care in inpatient spaces focused on the design and facilities of such spaces, showing that many nurses in Hospital A were comfortable providing care due to their use of the new building, while those in Hospital B focused on safety and restrictive practice issues related to hospital design. The emphasis on the lack of drainage in the toilet areas underlines the fact that women and nurses' safety, which should be always crucial, may not be considered in some cases, to the detriment of both parties; consideration of such factors should be a constant principle in mental health ward design. Sophia's positive

view of restrictive practices was seen as being mainly driven by staffing issues, although there are many clear calls to reduce these practices in the mental health literature. Mann-Poll, Smit, de Vries, Boumans, and Hutschemaekers (2011) indicated the existence of several important factors that must be in place to support reductions in the use of seclusion, including ensuring adequate staff-consumer ratios. This factor should be addressed urgently by Hospital B administrators, who should lead attempts to improve the lived space for their nurses and reduce restrictive practices.

Even when consumers display aggressive behaviours, which Sophia offered as a further reason for restrictive practices, it is likely to be possible to utilise alternative rooms better tailored for consumers, as is done in many other countries, if staffing levels and staff knowledge are adequate (Georgieva, 2012). Such rooms were available in Hospital B at the time of the interviews; they were known as high-risk or high-dependency rooms. Despite the presence of these high-risk rooms, however, nurses such as Catherine still asked for more seclusion rooms, and these requests may have been triggered by nursing shortages, as discussed by Sophia, or by a lack of mental health knowledge and skills among these nurses in terms of caring with consumers who present as over-excited. This potential lack of knowledge highlights the need for these skills to be reinforced by the nursing education department to allow nurses to identify non-coercive alternatives while caring for consumers. Non-coercive alternatives might also empower women to take control of themselves, enhancing the development of the necessary user-based recovery approach (Schrang & Slade, 2007) in the provision of nursing care.

As well as the nurses' perspectives on inpatient ward design, they also had distinct views about the lack of facilities in Hospital A, which affected their care provision. Lack of childcare was a concern, alongside the ongoing lack of access to food. The gap in childcare

facilities must be addressed by the employers in Hospital A in acknowledgement and support of the fulfilment of nurses' family care responsibilities, as this would allow the nurses to focus on providing high quality nursing care to consumers while on shift. Regarding the lack of food facilities, the nurses discussed the issues based on their experience of ward spaces without any access to food facilities due to Hospital A's rules: these nurses felt exhausted and starved, which impaired their provision of care to women with psychosis. Manahel viewed the need for food facilities as a key welfare issue for nurses that the hospital needed to address: 'I went to a course at another hospital for two weeks where I found that basic meals from breakfast and lunch are available for employees, something that could be considered as welfare for our hospital' (p. 2, lines 82-84). Ahd also offered a recommendation related to the provision of food facilities: 'The best thing they can do for us is to provide a good restaurant because [in the current situation] we starve' (p. 2, line73). She added:

A café is needed here to keep us alert and in a good mood for work. We work for a vital hospital, and we have been demanding such services for a long time, but no matter what we say [nothing happens]. If these services were provided, I could get my coffee and breakfast and quickly return to work. (p.2, lines 78-81)

The next section discusses the theme arising from nurses' views of the care they provide to KSA women with psychosis in terms of the need for healing spaces.

8.4 Theme 2: The need for healing spaces

The second theme arising from nurses' experiences of providing care to KSA women with psychosis regarding mental health facility spaces was *the need for healing spaces*. The nurses reported experiencing the spaces of the mental health facilities in which they provided care in various ways that can be understood through the lens of their need for a healing space. These embodied experiences were analysed using van Manen's (2014) existential of lived space. One of the nurses' experiences was also investigated using the lived body existential (van

Manen, 2014), as she specifically discussed her personal loss of motivation to work and provide care within the context of a space that lacked any form of garden.

The idea that aspects of place and space may mediate health is well-established (Bell, Foley, Houghton, Maddrell, & Williams, 2018). Moreover, the importance of hospital spaces with regard to treatment outcomes and, more generally, the wellbeing of consumers (Lawson, Phiri, & Wells-Thorpe, 2002) is also well established; in particular, mental health healing spaces are generally identified by features and aspects of the built physical environment intended to promote mental healing. Lighting and ambience, the colour and quality of the materials used, food quality, air conditioning, access to views overlooking green spaces, accessibility, and openness have all been found to have a positive impact on consumer experiences of wellbeing and recovery (Curtis, Gesler, Fabian, Francis, & Priebe, 2007; Reavey, Harding, & Bartle, 2017). It would be anticipated that mental hospital spaces should strive to create a homelike atmosphere for consumers, with features such as careful lighting effects and soft furnishings being used to enhance the creation of a supportive environment for healing (Waller & Finn, 2004). For consumers with psychosis, Golembiewski (2010) reported that those with schizophrenia in particular should be exposed to natural environments which offer strong positive affordances to their emotions and support recovery. It is also important to recognise the value of healing spaces in Islamic communities in general, as the context of the present study is the KSA, which is a strongly Islamic community. The pleasant effect of healing spaces, including gardens, is integral to Islamic culture, with meditation facilitated by a focus on God's beneficial creations such as plants being considered one of the most effective and efficient forms of Islamic worship, as well as being mentioned frequently in the Qur'an (Sabry & Vohra, 2013). It may therefore be assumed that the need for healing space is particularly relevant in the KSA community, and specifically for mental health consumers there who may benefit from this focus. In this

research, the need for a healing space for women with psychosis was certainly recognised as important in both hospitals, based on the nurses' perspectives.

Many nurses from both hospitals regretted the absence of gardens and recreational spaces in their mental health wards, specifically noting this when discussing aspects of their environments that impacted their mental health care experiences. Rebecca from Hospital B highlighted this in the following way:

[There is] no garden for the [consumers], and there [are] no games are available, so what we tell the [patients are to], [watch] TV or listen to the Qur'an. [But] how long can they listen? ...When the [consumer] hears voices, I need to divert her attention; what will divert her attention? OK. Come, and I will take you outside, come to sit down under the tree, come to play, come to dance, all of these will divert their attention. If you cannot divert their attention, what is the prognosis...? I am sure all the staff here [are] facing these barriers. (p. 2, lines 73-78)

Rebecca recommended that '[The] infrastructure should be modified, [with] some recreation spaces and gardens' (p. 3, line 87). These excerpts highlight Rebecca's frustration with the absence of gardens or games and her perception of the need for these to help heal the women with whom she works. She also emphasised the importance of these elements as a diversion strategy for those women who hear voices, again aiding their recovery. Rebecca would like to provide better care to women hearing voices by offering them diversions based on access to nature and recreational spaces.

Sarah from Hospital B also discussed why gardens and sunlight are necessary: '[Unless] you have a garden to take them outside and sit [with] them and get the sunlight, [consumers might] sit two to three months in the ward without vitamin D, [creating further] barriers [to care]' (p. 2, lines 62-64). Sarah emphasised the healing nature of sunshine in a facility, with natural sunlight acknowledged as maintaining and increasing vitamin D levels, which may reduce depression and improve sleep patterns and mental wellbeing (Penckofer, Kouba, Byrn, & Estwing Ferrans, 2010). Improved levels of vitamin D might also help some women

with recovery from symptoms of psychosis (Lakhan & Vieira, 2008), which in turn may help nurses such as Sarah provide better care; where women show some improvement, offering further access to a healing space may smooth the process of recovery.

Furthermore, the absence of gardens creates a jail-like environment for women with psychosis, according to Sarah, who noted that:

We do not have a garden outside, so most [consumers]... see this ward as a jail because it is...closed and because they [do] not understand why it is closed.... If you are [locked away from] other people, this is another thing [that is] like a punishment for them. [These are] the barriers [to care]. (p. 2, lines 58-61)

Sarah again stressed the need for gardens:

Here at the hospital, changing the set-up of this unit [to have] a garden for the [consumers] so they do not feel it is closed in like a jail [would let women with psychosis] see the sunlight...[and] breathe fresh air, that is the main thing. We cannot blame them for what they [might] do while it is closed, and they see only our faces. (p. 3, lines 96-100)

Manahel from Hospital A had a similar view to Sarah, reporting the perception of being jailed in the hospital: 'I wish ... the consumers' situations [could be] improved through entertainment and ventilation in an open place...the ventilation is not bad, but the building is like a jail with security guards' (p. 2, lines 51-52). Both Sarah and Manahel believed that the absence of healing spaces and the corresponding perception of being in an enclosed, locked ward could cause women with psychosis to have a heightened sense of being trapped. As Sarah noted, the main reason for this perception may be that these women do not understand why the ward is locked, and they may perceive their containment as punishment.

The locked wards in both hospitals were highlighted in the chapter background: considered alongside these nurses' perspectives on the containment of women, this helps develop understanding of the lack of healing spaces in these wards, while the nurses' views suggest that the ward environment overall is not helping to nurse consumers with mental illnesses.

The nurses in the study by Damane (2019) similarly felt that the physical structures of the

ward, with its locked gates, created a sense of confinement and a jail-like ward which they suggested was oppressive and frustrating to both nurses and consumers. Similarly, van der Merwe, Bowers, Jones, Simpson, and Haglund (2009) also saw nurses reporting experiencing the locked doors of their wards as being restrictive, comparing the conditions on such wards to those of jails, and noting that locked wards created more volatile environments for consumers, who often became upset as they experienced these environments as a punishment. Linking Sarah and Manahel's views about the locked wards with no gardens to similar examples in the literature helps explain that the nurses might experience offering care to women with psychosis in such a ward environment as unpleasant and frustrating. This frustration can also be discussed in terms of the additional care needed for women with psychosis who experience negative feelings and reactions due to the hostile nature of these locked spaces.

In contrast, when the need for a healing space is fulfilled, consumers may improve and recover more quickly, as Manahel noted. Novotná, Urbanoski, and Rush (2011) examined staff perceptions of client-centred design in mental health facilities in terms of workspaces, and their results supported the idea that client-centred design facilitates consumer recovery and reduces stigma. Such design also facilitates communication and therapeutic relationships among clinicians and consumers, as well as increasing team cohesion (Novotná et al., 2011). Improved workspaces with client-centred designs which facilitate the provision of care to women with psychosis are regarded by nurses such as Sarah and Manahel as an urgent necessity, and this should be considered in the design of mental health spaces.

Some nurses were concerned that the ward environment, particularly wards being locked, had negative impacts on the women with psychosis. For instance, Hafsa, a nurse in Hospital A commented that: 'I feel that the hospital's design is a barrier. When consumers with

psychosis are admitted to the hospital, they feel depressed. The place is closed' (p. 2, lines 46-47). Hafsa mentioned that the women in Hospital A appeared to feel depression, which she attributed to their lack of access to nature and green spaces, adding:

When I was at the emergency [department], there [was] no place that [consumers] could go out and walk; there [was] no garden, and they did not go out for treatment with occupational and recreational [therapy]. Sometimes, the situations in the emergency [department] sat there for three months. [Similarly], here in the inpatient ward, there is no garden, only a small open place [courtyard] with chairs. (p. 2, lines 47-52)

This promotion of low mood, which may be accompanied by low energy levels, may in Hafsa's view be a further risk for nurses in terms of their caring for women with psychosis, as nurses will have to offer additional care to tackle low moods and decreased activity among the women with whom they are working.

In terms of the need for gardens and fresh air among both women with psychosis and staff, Rachel from Hospital B said, 'We need a garden for our [consumers], I think our [consumers] need more oxygen, [and so do the] staff...that is [an] important thing' (p. 4, lines 160-161). Madison, from the same hospital, similarly recommended creating a garden space for women with psychosis there, emphasising the struggle that women faced when they sought to access the current garden space that Hospital B does have, which is in the male ward:

We need the garden here: the [consumers] need to experience the weather, the air, the sky. The garden is inside the male ward, and we [must] call the male ward and ask them about the availability of the garden and check that there [are] no male [consumers there]. Then we open that door and pass by and call them to close the door...we need...a garden for this ward...this is not...an [effective mental health] ward, [it is] not appropriate for [mental health consumer]. As I said: we do not have a garden. (p. 3, lines 91-97)

Both Rachel and Madison discussed the need for gardens in Hospital B to support their caring for women with psychosis in an environment that would be more conducive to their recovery than the current wards. Designing hospitals in such a manner as to enable women to enjoy the outside and to have access to fresh air would support their recovery as mental health

consumers, and allow them to feel more comfortable in the hospital (Shattell, Andes, & Thomas, 2008). Further, a more comfortable atmosphere is likely to help nurses such as Rachel and Madison to provide better care. Evidence-based design in mental health architecture, which generally enables access to nature, was recommended by Golembiewski (2010). This mirrors Rachel and Madison's view that they want their consumers to experience a healing space and exposure to nature in a way that suggests this may also enhance and motivate the nurses' care for women within such an environment.

Sabah from Hospital A mentioned that she lost the motivation to work with women with psychosis because of the lack of gardens:

Previously, the ward was terrible, but [there was] a garden. There is no garden in this ward. There is a [courtyard], an open room at the end of the hall, but it is empty [of greenery]. Nothing is motivating me to continue working here. (p. 2, lines 68-71)

Sabah's view reaffirms the need to provide care for women with psychosis in spaces that offer access to a healing garden for the good of both the women with psychosis and the nurses involved. The need to experience motivation to be productive in nursing care work was examined by Guenther and Hall (2007), who found that access to daylight and views of nature were essential to supporting such productive motivation: work environments in walled areas were found to be particularly detrimental to motivation, leading to intense stress levels among nurses. This concept of stress was further touched on by Sabah, who appears to recognise the need to enhance her motivation and performance by working in a well-designed healing space, and previous work suggests that fulfilling such needs leads to better care and, therefore, to better outcomes for consumers (Commission for Architecture and the Built Environment, 2004), such as the women with psychosis considered in this research.

The nurses' views presented in this theme are among the first to depict the experience of caring for women with psychosis in terms of *the need for healing spaces* within KSA mental

health facilities, specifically in female wards. This need for healing space was understood with the support of the lived space existential proposed by van Manen (2014), and the nurses added new insights based on their experiences that revealed the perceived and recognised lack of healing space and the ways this impacted their care, even to the extent of one of them (Sabah) experiencing a complete loss of the motivation to provide care.

Recommendations to help nurses in providing care for women with psychosis can be identified based upon the nurses' perspectives presented above. As the nurses were constrained by the spaces available, many of them mentioned the need for better therapeutic landscapes within facilities. These mental health hospitals need to establish access to gardens, fresh air, sunlight, ventilation, and recreational spaces, as well as considering the provision of more open areas to decrease the generation of a jail-like environment. Alongside these needs highlighted by the nurses, however, further research in this area, with an increased focus on nurses' experiences of care as moderated by the attributes of design of KSA mental health facilities, is necessary to support the introduction of amendments to enhance consumer recovery.

This section highlights the nurses' recognition of the need for healing spaces to allow them to offer the best possible care to women with psychosis in KSA mental health settings, particularly inpatient settings. The next theme emphasises the nurses' perspectives on offering care in OPD spaces.

8.5 Theme 3: Nurses' lived spaces in outpatient settings

The third theme identified by examining nurses' perspectives on the care they provide to KSA women with psychosis in mental health spaces was their experience of offering care in OPDs, based on van Manen (2014) lived space existential. All views contributing to this

theme were gathered from nurses working in Hospital B's OPDs. The interviewees from Hospital A did not highlight any perspectives on OPD design, but instead discussed other aspects of their experiences of care in these settings.

Anna identified an issue with the assessment clinic also being used as the nurses' lounge, rather than this being a separate space: 'The set-up is not good because we do not have the nurses' lounge; that nurses' room... is also the [assessment] room, procedure room, and locker room for the staff' (p. 2, lines 78-80). Anna saw these multiple uses of the assessment room as a concern regarding provision of care, noting problems with nurses being able to achieve adequate rest and sufficient breaks due to the limited space available in the clinic area. If the room was needed to assess women attending appointments, the nurses were expected to rush their breaks, even if they were eating. This experience of having limited space to eat or relax was viewed as compromising nurses' energy and dietary rhythms, which, in turn, caused them to experience a lack of energy, impacting their ability to care for consumers.

The waiting areas for consumers in Hospital B were also small, with a limited number of chairs, according to Anna:

[The] female waiting area is not [large] enough for the [consumers], especially after the holidays ... when all the consultants come back, each of them will be fully booked, and sometimes during Mondays and Wednesdays, the hallways are filled with [consumers]...they talk, talk, talk, and when the nurses tell them to go to the waiting area, the [consumers] answer 'What can I do, [there are] no chairs there', and even the doctors complain. (p. 2, lines 81-86)

Daisy also noted the impacts of this limited space, agreeing with Anna's views on the issues with the waiting area and noting that such limitations are not suitable for mental health care:

I do not think...we have enough space here; this place [is] not suitable for [mental health] clinics. I only have six months experience here, but I feel

[that it is difficult]. I do not feel comfortable in this area; we need...[better] facilities. (p. 2, lines 54-56)

Caroline also noted that ‘The infrastructure here is not suitable for the [consumers]. It [the OPD area] is too narrow, I think, for safety, and it is a big problem; this is not suitable’ (p. 2, lines 65-67). The nurses’ narration of their experiences in terms of the physical aspects of the clinics being too limited and narrow reflect their perceptions of this as a challenging environment in which to offer care; Daisy and Caroline specifically noted that it is not suitable for mental health consumers. The researcher’s observations support the nurses’ perspectives, with the OPD area having very narrow halls, one of which is only wide enough to accommodate a single person at a time; similarly, the waiting area is very small, and at peak times, some consumers, and many of those accompanying them, cannot find places to sit.

Treatment space can be considered a significant predictor of consumers’ satisfaction (Sherwin, McKeown, Evans, & Bhattacharyya, 2013). If consumers with mental health issues are kept waiting and confined in small, narrow, noisy, and crowded areas, these locations will become overly arousing, making anger and aggression likely to become more prevalent (New South Wales, Ministry of Health [NSW Health], 2011; Slone & Friedman, 2008). The researcher’s experience of the conduct of interviews in OPD areas included observing multiple expressions of anger by consumers or their accompanying relatives, and these most frequently erupted at peak times. This anger may undermine nurse safety, as Caroline noted. The nurses’ views in this theme reflected their experiences of care provision for KSA women with psychosis in OPD spaces. Their lived space experiences were explored to understand the impact of such spaces on this care (van Manen, 2014). Anna discussed the limited space available for the nurses to eat or take a break, while she and the other nurses criticised the limited waiting areas available to female consumers and their families.

To overcome these issues and to help nurses provide better care in comfortable OPD areas, some nurses offered recommendations related to improving the design of the OPD space; as Caroline stated, ‘The infrastructure needs to be expanded and ventilated’ (p. 2, lines 72-73). The NSW Health (2011) similarly recommends that waiting rooms should be designed to reduce anxiety and aggression and to help nurses to initiate care and improve consumer flow. Redesigning waiting areas in the hospitals requires proactive management input in terms of ensuring their design will benefit consumers, carers, and all staff, including nurses (NSW Health, 2011). It is therefore recommended that the management of Hospital B should act to support the nurses by expanding the waiting areas to facilitate their provision of better care.

8.6 Summative discussion

The nurses participating in this research held various views on their experiences of caring for women with psychosis in KSA mental health physical spaces. Their lived space experiences were explored, and as many perspectives were deeply linked to the impact of living with hospital rules that limited access to facilities, the lived thing was used to understand this impact (van Manen, 2014). Within these spatial concerns, the lived body existential was used to reveal many nurses’ embodied experiences of exhaustion, hunger, and loss of motivation to provide care (van Manen, 2014). Analysis of these views identified three themes: *lived experience of giving care in inpatient spaces, the need for healing spaces, and nurses’ lived spaces in outpatient settings*.

Regarding caring for women in inpatient spaces, one of the Hospital B nurses noted the inherent compromise of safety for nurses while caring for women caused by limited drainage in the toilets. Some nurses in Hospital B also felt satisfied with the facilities for applying restrictive practices, which they felt improved their care experience, although this perspective challenges the current global movement towards reducing the use of such practices. These

views, and particularly the belief that restrictive practices improve nursing care, might reflect these nurses' reliance on providing physical care only, which does not empower women to help and take control of themselves, suggesting that these nurses are using service-based recovery techniques (Schrunk & Slade, 2007) in their care for women, highlighting a potential gap in nurses' care provision. Many nurses in Hospital A emphasised the lack of facilities in the inpatient wards to offer support for their work, including the lack of childcare and the absence of food or drink facilities inside the wards due to Security Department rules. These lacks caused nurses to experience exhaustion and sickness, increasing the occurrence of sick leave and directly affecting the care provided. The nurses generally recommended improving these facilities to improve their experience of providing care to women with psychosis.

Inpatient environments should be designed as healing spaces for women with psychosis, and this was a significant concern for many nurses interviewed. These nurses focused on how their experiences of caring were compromised due to the absence of healing spaces, and they, therefore, suggested the need for the recognition and development of spatial healing in their respective hospitals to improve their experiences of care. Such improvements were suggested to include providing gardens and recreational spaces, offering access to fresh air and sunlight, and ventilating the wards more effectively. Currently, facility deficits such as the lack of gardens or greenery exacerbate nurses' lack of motivation, as highlighted by Sabah. These nurses' experiences can be viewed as strong recommendations for improving care within healing spaces, based on the recognition that these spaces should be redesigned to make such care more comfortable and efficient.

The final identified theme, nurses' experiences of providing care in Hospital B's OPD spaces, is best presented by Anna's discussion of the challenges nurses face in terms of eating and

taking a break in a room that is not solely allocated to such purposes, and which is used for the assessment of consumers. Such use causes nurses to rush their breaks, potentially compromising their recuperation of the energy they need to look after consumers. Other nurses emphasised the impact of the inadequate narrow waiting area on the care they can offer to consumers, with Caroline expressing this in terms of safety risks in such small spaces.

The next chapter examines the second major theme emerging from nurses' experiences of providing care to KSA women with psychosis, highlighting their understandings and emotions related to their provision of care for these women.

Chapter Nine: Nurses' Experiences of Providing Care to Women with Psychosis in KSA: Understandings and Emotions

9.1 Introduction

This chapter presents the second major theme which emerged from the nurses' experiences of providing care to KSA women with psychosis; this specifically addresses the nurses' understandings of, and emotions about, their experience of providing care for women. This theme, in common with the others, draws upon several of van Manen's (2014) lifeworld existentials. However, it is based on the central perspective of the lived body, which was used as a focus for a hermeneutic analysis of the nurses' lived experiences in terms of the understanding and knowledge, insights, motivations, feelings, and emotions they develop and experience as part of their provision of care. To support the ideas generated by considering the lived body existential, other lifeworld existentials were added, to enable a more in-depth exploration of the several different perspectives of nurses in relation to these understandings and emotions. The existential of lived cyborg (van Manen, 2014) was helpful in understanding how the nurses were affected by their workplace systems. Several nurses highlighted relationships with others, which may be best understood through the lived self-other existential proposed by van Manen (2014). Several nurses were also affected by living through specific situations in their work, such as a limited training and staff shortages, which were analysed using van Manen's (2014) lived things existential. Finally, nurses' experiences of time limitations due to the shortage of nursing staff were explored further by applying the notion of lived time (van Manen, 2014).

The overarching theme of this chapter is nurses' understanding of, and emotions experienced during, the provision of care to women with psychosis. This overarching theme is investigated more closely under two headings: *understanding psychosis while providing care to women with psychosis* and *emotional labour experienced when caring for women with psychosis*. These two themes are presented together with further related sub-themes in the relevant sections in this chapter based on the integration of various nurses' views, discussions, and reflections.

In the KSA context, the understandings developed by nurses in the provision of care to people with mental illness was explored by Alshowkan (2017). The nurses in that study suggested that they found it hard to understand mental illness and offer care, and reasons for this included their lack of relevant undergraduate education and knowledge and their ongoing lack of mental health nursing training. However, prior to the present study, no studies have explored nurses' understandings of and emotional experiences during their provision of care for consumers with psychosis in general or, more particularly, to women with psychosis in the KSA context. This chapter seeks to shed light on the experience of nurses in this situation, highlighting the understandings and emotions they develop whilst caring for women with psychosis in the KSA context.

9.2 Theme 1: Understanding psychosis while providing care to women with psychosis

Nurses' understanding of psychosis was the first theme to emerge from exploring nurses' understandings of, and emotions experienced while, providing care to KSA women with psychosis. The nurses' perspectives of providing care revealed in this theme were explored using van Manen's (2014) lifeworld existentials, which offered a way to analyse the nurses'

embodied understanding of psychosis; this proved to be linked to several views about cyborg experiences, relationships, time limits, and lack of education and training. This theme was also further divided into the following subthemes: *Hospital A nurses' understandings of psychosis, Hospital B nurses' understandings of psychosis, and nurses' understandings of medication adherence and relapse in psychosis* (See Table 9.1).

Table 9.1: Theme of nurses' understandings of psychosis while providing care to women in KSA and sub-themes

Theme 1: Understanding Psychosis While Providing Care to Women	
Sub-theme 1	Hospital A nurses' understandings of psychosis.
Sub-theme 2	Hospital B nurses' understandings of psychosis.
Sub-theme 3	Nurses' understandings of medication adherence and relapse in psychosis.

As revealed in Chapter Two, nurses' knowledge about the pathology of illnesses is a basic requirement for work in nursing. Therefore, nurses working with consumers with psychosis must develop an understanding of the illness in order to improve their mental health nursing skills while providing appropriate care to consumers (Engqvist, Ferszt, Åhlin, & Nilsson, 2009). The necessity of the understanding of psychosis developed by nurses working in mental health units and related services was affirmed by Engqvist, Nilsson, Nilsson, and Sjöström (2007) to be a fundamental aspect of this type of nursing work. It is essential that as soon as a relevant consumer is hospitalised, nurses can use their understanding to foster a better working relationship with that consumer (Sebergesen, Norberg, & Talseth, 2016). During this working phase of relationships, nurses can use their understanding also to explore the consumers' experiences of symptoms (Merritt & Procter, 2010). In addition, nurses can use the understandings developed from their experiences of offering care to make each consumer's time in the hospital as beneficial as possible: such understanding can, for example, help nurses to apply various therapeutic nursing interventions to address consumer needs (Engqvist et al., 2007).

The nurses in this research revealed how their understanding of psychosis was developed through their lived experiences of offering care to women with psychosis, as noted in the following sub-sections.

9.2.1 Sub-theme 1: Hospital A nurses' understandings of psychosis

The first sub-theme in nurses' understanding of psychosis while providing care to KSA's women with psychosis is *Hospital A nurses' understandings of psychosis*. The views of nurses at this particular hospital were initially explored using van Manen's (2014) existentials as a way to reveal their embodied understanding of psychosis. This allowed some of their experiences of relationships, education, and in-service training, as well as their experiences of having limited time to attend training due to nursing staff shortages, to be investigated to develop an understanding of how these experiences affect their understandings of psychosis.

Hospital A nurses highlighted their understandings of psychosis based on their perceptions and knowledge of psychotic disorders, symptoms, and possible causes. Many nurses discussed how their provision of care to women with psychosis had developed their understanding of psychosis, although this was impeded by the presence or lack of education and in-service training, a point stressed by many nurses. In terms of education and in-service training in the KSA context, there are currently no standards for specialised mental health education for nurses assigned to work with mental health consumers. As explained in Chapter Two, the most recent *Executive regulations of mental health care law* by the MOH (2021a) states that nurses working in mental health must hold a Bachelor's degree or Associate Diploma in nursing and be licensed to practise as a nurse by the competent authority. Furthermore, as explained in Chapter One, the first KSA mental health atlas completed by Al Habeeb and Qureshi (2010) highlighted the fact that nurses in the country tend to start working with mental health consumers on completion of their general nursing degree,

without receiving any specialised training. They rely on the mental health training offered by the relevant facilities to improve their skills (Al Habeeb & Qureshi, 2010). Furthermore, no research to date has explored the content of mental health nursing subjects in the KSA Bachelor's degree of Nursing. Based on the researcher's experience in undergraduate teaching, however, mental health issues are included in two subjects: theoretical and practical subjects in mental health nursing, along with a brief clinical placement.

Taking the eleven nurses from Hospital A interviewed in this research as a reference point for discussion of the sub-theme of qualification standards for those working in the mental health nursing field, as noted in the *Nursing demographics* sub-section in Chapter Six, there are significant differences in the levels of education achieved by nurses working in this field. Six of the nurses from Hospital A had Diplomas in General Nursing, which require two years of study in general nursing after high school, while three had Higher Diplomas in General Nursing, which require three years of study in general nursing after high school. It may be assumed that no, or at least an insignificant amount of, specialised mental health nursing education and training are offered during these two courses, as the study periods are very short: training is likely to be limited to physical care only. The remaining two nurses at Hospital A held Bachelor's degrees in General Nursing, which require four years of study in general nursing, including at least one subject on, and brief practical training in, mental health nursing.

Fadwah from Hospital A expressed her perceptions of psychosis in this way:

Norah: Tell me about your experience of caring for women with psychosis.

Fadwah: What do you mean by psychosis?

Norah: It is a group of disorders in which the person has [some] detachment from reality. Some of its significant symptoms are hallucinations and delusions. ... schizophrenia is one of [the most obvious] psychotic disorders.

Fadwah [after nodding her head]: Consumers with psychosis repeatedly scream, and they are aggressive. They do not want to talk to anyone. Sometimes they talk to themselves, and some others throw food. (p. 1, lines 21-26)

Hafsa discussed how she perceived psychosis in a manner that may be interpreted as representing her understanding of psychosis:

Not all of them [women with psychosis] are aggressive... I noticed that most of them are quiet, not social, isolated, hide a lot, and are distracted; they do not give you clear words about their distraction. They have slurred speech and do not give you a precise answer; most of them often do not respond. (p. 1, lines 31-34)

Fadwah and Hafsa's perspectives reveal several perceptions of psychosis. Fadwah had to begin by asking for a definition of psychosis, which might explain some of her limited perceptions of psychosis. This question suggests that this terminology is unknown to her, and she has not been taught about psychosis. However, after the researcher presented a brief explanation to her, she immediately offered some perceptions of psychosis, acknowledging the definition and adding her perceptions of some specific symptoms of psychosis.

Aggressiveness was the first symptom addressed by both Fadwah and Hafsa; this was followed by their opinions of the relevant women's silence and isolation from others, which may reflect social withdrawal. Hafsa saw women talking to themselves as a symptom of psychosis, which might be assumed to be linked to hallucinations. She also considered throwing food to be a symptom of psychosis, perhaps reflecting impulsivity. According to DSM 5 (2013), hallucinations and social withdrawal are often found in psychosis, while psychotic symptoms can sometimes lead to aggressiveness and impulsiveness (APA, 2013). Distraction, also perceived by Hafsa as a symptom of psychosis, is also described in DSM 5 (2013) in terms of the reduced attention of consumers with psychosis. Hafsa also mentioned slurred speech, a negative symptom of psychosis associated with diminished emotional expression (APA, 2013). This slurred speech may also be related to over-sedation, a side effect of antipsychotic medication, which is considered a secondary negative symptom to the

psychotic experience (Kirschner et al., 2017). Fadwah, despite not initially recognising the term *psychosis*, nevertheless reflected a sound understanding of the experience of observing and caring for women with psychosis, based on her experience of caring for women with psychotic symptoms; nevertheless, her lack of a broader understanding or framing of psychosis and significant symptoms of this illness is a concern. In terms of her perspectives on in-service training and education, she discussed the limited number of courses available and the lack of time to attend such courses, which might help explain her limited understanding of psychosis. She said:

The training and courses set [up] for the nurses are infrequent... [and] we have no time to attend. Most of us do not attend because of the lack of nurses. The number of nurses is not sufficient for taking care of thirty women [in the ward]. If two nurses attend [at once], it will cause trouble, which would be the nurse's responsibility. (p. 2, lines 63-67)

Saleha similarly noted experiencing time constraints on attending training sessions. She said:

I think that the nursing training provided in the hospital is...good. We have a day per week for training lectures, but the schedule and the lack of nurses can prevent us from attending such lectures. If we have the time, we will attend them. (p. 2, lines 76-78)

Fadwah's and Saleha's perspectives highlight the fact that there is currently no protected time for workforce upskilling due to a shortage of nursing staff, a factor likely to impact nurses' understandings of psychosis as they provide care to women with this illness. Overall, time constraints are a significant issue for mental health nurses (Glantz, Örmon, & Sandström, 2019), and their impact on training and education feature significantly in Fadwah's and Saleha's views.

In terms of Hafsa's understanding of psychosis, she also offered some more specific insights into psychotic symptoms based on her experience of offering care to women with psychosis. However, they revealed a lack of understanding of several of the main symptoms of psychosis, potentially related to the factor she stressed in another segment, the lack of

training in the qualification stage: ‘We graduated without training in this [mental health care], and [yet] we are employed [to work] directly [with] these consumers’ (p. 2, lines 65-66). This lack of prior training may explain Hafsa’s lack of a broader understanding of psychosis symptoms, and Malak similarly acknowledged that no targeted training is offered before nurses begin their mental health careers, nor is efficacious in-training to enrich understanding of psychosis guaranteed:

There are [limited] courses. When I first came to work here, they told me that I would learn everything by practice and experience, and they did not give us any background on psychosis nor schizophrenia. All training we attend here [covers the] same things. (p. 2, lines 67-69)

This lack of prior training was also emphasised in Ahd’s perspective: she highlighted that her understanding of psychosis was limited to her accumulation of experience, as she had no prior education or training in this field:

Before [at the beginning of her career], I knew nothing about the meaning of psychosis; whenever I heard this term, I could not define what [it meant]. Since I have dealt with [women with psychosis], I know what it... means. (p. 1, lines 13-15)

As with Hafsa and Malak, Ahd had no prior understanding of psychosis when she began her career in mental health. As indicated previously in the discussion about KSA context (Al Habeeb & Qureshi, 2010; Ministry of Health, 2021a), nurses’ educational qualifications are limited regarding specialised mental health education and training. In addition, and as indicated earlier, most nurses at Hospital A had no significant prior education on looking after women with psychosis; Hafsa, Malak, and Ahd’s perspectives highlight the importance of this. These nurses lacked education about mental health during their undergraduate education and training periods prior to coming to work with consumers with mental illness, in a similar manner to the situation reported by Jones and Lowe (2003). This issue was also identified by Happell and McAllister (2015), who argued that models of undergraduate nursing education do not meet the standards for many nurses to develop the requisite skills

and knowledge in mental health nursing to offer successful care. The level of knowledge and preparation provided for mental health nurses remains inadequate, and early career nurses struggle as they enter practice, as their work in the mental health field requires them to deal with many different and highly complex mental disorders, including psychosis (White et al., 2019). This struggle is reflected in the nurses' views, particularly in their highlighting of their limited basic mental health education and training skills, which they feel impact their understanding of, and affect their ability to care for, consumers with psychotic disorders.

Afrah viewed psychosis as a confusion of consciousness and a tendency to forget things:

What I know about psychosis is that the consumer's consciousness is different from usual; the consumer forgets some essential things, and she does not know how to wear her clothes, eat, or behave. She is not aware of reality, as if she was newly born. (p. 1, lines 14-16).

Afrah then more specifically discussed her experience of caring for women with psychosis:

We take care of a consumer from the morning, at the beginning of our shift, till the end of the shift at 4 pm; when she wakes up, we tell her to shower and eat [before] meeting the consultant. After that, she takes a break to pray and, in the afternoon, she mostly sleeps; that is usually the routine. (p. 1, lines 21-24)

Afrah's understanding of psychosis was related most specifically to confusion of consciousness and the forgetting of crucial things. While confusion of consciousness is not reported in the literature as a psychotic symptom, the forgetting of important things may be related to recognised cognitive deficits that occur in some situations of psychosis that act to the detriment of memory function (APA, 2013). Afrah also mentioned that women with psychosis often do not know how to look after themselves in terms of dressing, eating, or behaving in public. This perception corresponds with reports in DSM 5 (2013) of levels of self-care in consumers with psychosis being markedly below the levels achieved prior to psychotic onset, which may also be related to cognitive impairments which cause the processing of the need to care for oneself to be slower or even totally impaired. Afrah

suggested that women were not aware of reality, which might be identified as detachment from reality, which she also noted.

She then talked about her experience of caring for women with psychosis, discussing the provision of care in terms of asking such women to take showers, eat, and have afternoon rests. This perspective highlights a tendency to offer physical and custodial care without consideration of any true mental health care component. Afrah's view of how to offer care appears to place her care within a service-based recovery approach (Schrank & Slade, 2007), with no active encouragement of women to share decision making about their daily routine to reduce dependence on nurses. Generally, Afrah's examples of psychotic symptoms in the first excerpt suggest that her understanding of psychosis focuses only on the cognitive deficits represented by memory changes and low self-care. She also believed that confused consciousness is a part of psychosis, despite this not being presented in the literature. These examples reflect a certain limit to Afrah's perceptions about psychosis based on her experience. In addition, her usual routine for providing care to a woman with psychoses, outlined in the second excerpt, is notable for involving only physical care. This limited understanding of psychosis and the offering of purely physical care seen in Afrah's views may well be results of Afrah's limited education and training in mental health.

In terms of the nurses' understandings of the possible causes of illness, Majidah and Malak from Hospital A shared a belief that the main cause of psychosis was illicit drug use. Majidah said, 'In my experience, I think that 90% of ... psychosis incidence results from drugs, such as amphetamines' (p. 1, lines 13-15). Malak had worked previously in the addiction ward in Hospital A, and she also talked about drug-induced psychosis:

Most of the [women with drug induced psychosis] were on amphetamines, with apparent symptoms. They were nervous most of the time, suffering from hallucinations, [offering] verbal abuse against us, or [the] family. [A woman] can hit, harm and attack anyone. Consumers who take cannabis are

not aggressive, but they can harm themselves because [these women with psychosis] do not sleep adequately. (p. 1, lines 15-19)

Majidah and Malak's views suggest that they think that some women with psychosis abuse drugs such as amphetamines or cannabis. Psychosis may, as noted previously in Chapter One, in some cases, become a consequence of prior substance use, known as substance-induced psychotic disorder, which is considered a secondary psychotic disorder (APA, 2013). In the KSA context, Hussein, Elsheshtawy, and Hafiz (2015) reported that 39% of individuals of both genders with first-episode psychosis were users of various substances; the most commonly used substances in this context were stimulants, followed by cannabis. That study, therefore, somewhat supports Majidah and Malak's perceptions that using substances is a cause of psychosis in KSA. However, Majidah stated the belief that 90% of psychosis is caused by drug abuse, which significantly exceeds the findings of Hussein et al. (2015), who report a prevalence of about 40%. This variance might suggest that Majidah has a lack of understanding about the prevalence of drug-induced psychosis among women.

Another example of potential misunderstanding arose when Majidah discussed her care experiences with women with psychotic symptoms, offering further insight into her understanding of psychosis. Majidah gave an example of caring for a woman with false thoughts: 'If a woman complains that she cannot move, I talk to her, and convince her that she can' (p. 1, line 34).

Similarly, Rabab discussed her experience with responding to women with false thoughts:

Correction of thoughts depends on many things. When you try to correct the thoughts of some women, it is as though they are just stubborn, while with other women, we can correct [their] thoughts somehow. In addition, some women, when you correct them... It is as if we fix their thoughts, when you discuss their thoughts, [they] may be aggressive saying, 'do not say something', or 'say another thing'. There are some women you can correct [and] they may accept [it]...Others say, 'No, I am a prince's wife' and [this is their] firm belief. (p. 1, lines 28-35).

Majidah's and Rabab's discussion of their experiences of correcting false thoughts in women as part of providing care may identify further limits to their understandings of psychosis. While there is some debate as to whether mental health professionals can successfully challenge consumers' delusions, the literature generally suggests that they attempt not to discuss consumers' delusions at all, in order to avoid inadvertent collisions with consumer beliefs (McCabe & Priebe, 2008). This is important, as the consequences of such collisions can include increased aggression, as indicated in Rabab's observation that some women become aggressive when their thoughts are discussed. As noted earlier in Chapter Two about nurses' roles in managing delusions, nurses must demonstrate that they accept that the consumer has a certain belief, while making it clear that they should reinforce reality to help the consumer avoid focusing on false beliefs (Townsend & Morgan, 2018). Furthermore, Engqvist et al. (2007) highlighted several therapeutic nursing interventions which aim to reconnect women experiencing delusions with reality, and these are based on understanding and accepting what is going on with the woman from her perspective, rather than any discussion of *right* or *wrong* with reference to the woman's beliefs. This process certainly does not involve *correcting thoughts* in the manner Rabab discusses, and these excerpts also suggest that Majidah had a similar belief that a woman with false thoughts should be convinced of the falsity of those thoughts. While Rabab's view was that the correction of thoughts did work with some women, although not with others, she gave no more explanation for such differences.

These perspectives indicate that Majidah and Rabab have a limited understanding of psychosis, resulting from their lack of training and education. In terms of their views about their training and education, Majidah stated: 'As for me I taught myself and searched for external sources to obtain the necessary knowledge' (p. 2, lines 45-46), while Rabab affirmed: 'We miss the training and the good education' (p. 4, line 158). Her view was

reinforced by her comments that some training was offered, but that it was not motivating or relevant: she said, ‘there is training [sessions] but it is boring, as if they are explaining it on TV and someone is reading from a book’ (p. 5, lines 184-185). Majidah stressed that she relied on her own efforts to gain knowledge about psychosis, which further confirms the lack of training and education highlighted in Rabab’s view. This also highlights that reliance on self-learning is inadequate, as shown in Majidah’s responses to false thoughts among women with psychosis, with her knowledge only gained through trial and error, with no real evidence to support it. Such knowledge is not informed by evidence-based practice, which is a major consequence of the lack of targeted training and education which underlies Majidah and Rabab’s similar limited understandings of how to respond to false thoughts when providing care.

Overall, the responses from nurses at Hospital A identified this sub-theme as representing the ways in which they understood psychosis based on their experience of caring for KSA women. Using van Manen’s (2014) lived body existential, the nurses’ understanding of certain symptoms, disorders, and causes can be recognised as being part of, and informing, their overall understanding of providing care to women. Nurses’ relationships with the women were also explored, as these embodied experiences also help nurses understand psychosis. The nurses offered several examples of various aspects of psychosis; however, in many situations, their views reflected a lack of understanding of psychosis more generally. Afrah, for example, perceived confused consciousness to be a psychotic symptom, while Hafsa’s understanding of psychosis was limited to a narrow range of negative symptoms. Some nurses further highlighted their understandings of psychosis as having been developed mainly through their experiences of providing women with care or otherwise engaging in self-directed learning.

The nurses' experiences of having few opportunities to receive education and in-service training and their limited time to attend such training as is available due to the shortage of nursing staff were analysed based on their impact on nurses developing their understandings of psychosis. Many nurses stated they lacked prior training and education about psychosis before beginning work in this field, and had limited understandings of psychosis, having gained their current understanding through their cumulative experience of care provision rather than any exposure to targeted education. These nurses have incomplete and flawed understandings of psychosis, and it is vital for academic facilities to address the revealed need for more evidence-based mental health nursing education. Such education would enrich nurses' understanding of psychosis, offering a way for nurses to learn how best to provide care for women with psychosis, before they begin working in mental health settings. The inadequacy of nurses' understandings of psychosis also highlights the need for nursing students to study specific and discrete mental health nursing units in their preregistration nursing programs (Happell, Wilson, & McNamara, 2015). Majidah specifically recommended that 'a nurse [in this facility] should be chosen to be responsible for the mental health department, [who is] not [from the] medical or surgical departments' (p. 3, line 116-117).

In terms of graduate nurses, as pointed previously in Chapter Two, the ACMHN (2016) recommends, that all nurses working in mental health services should be RNs who either have existing postgraduate mental health nursing qualifications or are enrolled in postgraduate mental health nursing programs. Hafsa discussed the need for postgraduate education in these terms: 'I would like [it] if there were a chance to complete [my education] and develop. I would like this education to be...concentrated on mental health' (p. 2, lines 63-65).

Rabab also viewed the existing in-service training as uninteresting, which may have contributed to her limited understanding of how best to respond to women having false thoughts. However, the other nurses simply recommended the provision of more in-service training and education to enrich their experience of providing care to women with psychosis, with Malak specifying several ways in which nurses might improve their understandings of psychosis:

They should present specialised courses. They should [teach] diagnosis and teach us how to handle consumers, and ... allow staff to attend a [course] for a whole week to [let] them obtain adequate knowledge about psychosis, then to let them take a break for four months [before starting another] course [about] another illness. [Currently], whenever we receive a woman, not all nurses understand her diagnosis. (p. 2, lines 70-74)

Saleha similarly indicated that the nurses need more advanced and regularly updated training in mental health to improve their experience of providing care: she said, ‘We need advanced training for nurses because science is developed every day and we must [keep up with] with these updates to provide the appropriate care [and] services’ (p. 2, lines 78-80). The scope of Hafsa’s, Malak’s, and Saleha’s recommendations reveals the nurses’ awareness of the need for in-service education and training to allow them to develop a better understanding of psychosis. Lorem and Hem (2012) observed that such education of mental health professionals increases understanding of the clinical processes of psychosis, and when a solid foundation of evidence-based education in mental health is laid, the accumulated knowledge gained through care provision can then be informed by such education.

The Hospital A nurses’ understandings of psychosis were investigated in this sub-theme. Similarly, in the following sub-theme, *Hospital B nurses’ understandings of psychosis* are highlighted.

9.2.2 Subtheme 2: Hospital B nurses' understandings of psychosis

The second sub-theme was identified based on Hospital B nurse's views of their understandings of psychosis developed while providing care to KSA women with psychosis. These views were similarly investigated using van Manen (2014) existentials. Many related experiences were also explored, including nurses' relationships with the women, the ability to offer only limited care in some clinics due to time limitations, the perceived impacts of technology on psychotic experience, and nurses' educational and in-service training experiences. These experiences were analysed in terms of their impacts on nurses' understandings of psychosis when providing care to women with psychosis.

Within this sub-theme, many nurses in Hospital B described their understandings of psychosis through their experience of care provision. Some insights were engendered about education and in-service training, which were generally perceived to affect nurses' understandings of psychosis when providing care. The nurses from Hospital B's clinics specifically explained their experience of providing limited care as influencing their understandings of psychosis.

In terms of how these nurses understand psychosis while providing care, Rachel listed various *types* of psychosis; she also revealed a belief that technology had an impact on symptoms in some women:

Psychosis [appears in] different types, there is schizophrenic [sic], ...manic with psychosis, bipolar with psychosis.... [Some consumers] with psychosis are highly elated [and have] psychosis. Some [consumers] have ideas of reference: sitting in front of the TV, they say 'the man talking is talking only about me', and we have [Closed-Circuit Television (CCTV)], a system monitoring the [consumers] inside their rooms, so ... they have the idea that there is something broadcast [about them]. These are types of psychosis we have seen in [consumers]. (p. 2, lines 64-70)

Rachel mentioned several views that, taken together, can be said to form her understanding of psychosis, with an emphasis on schizophrenia, which is a classic psychotic disorder, and

manic and bipolar disorders with psychosis, with the latter category referring to various mood disorders with psychotic features (APA, 2013). She began discussing her perspective on symptoms by noting some women's sense of elation accompanying various psychotic features, as well as some women having skewed ideas of reference as a symptom of psychosis, such as believing that a person on TV is talking about them, or that CCTV footage is being widely broadcast (APA, 2013).

Based on the researcher's observations in both hospitals, CCTV in both hospitals was used in the seclusion rooms, as well as in the bedrooms of some women who were deemed to be at high risk of harming themselves or others. The CCTV feeds monitoring women at high risk were sent to the nursing stations 24 hours a day. The head nurse and charge nurse in each ward spend most of their time in these stations, where they can monitor the women as they carry out their administrative duties. In the event of any sign of elevated risk in the women's behaviour being displayed on the monitors, the nurses can intervene.

Reflecting on my work as a mental health nurse, the presence of multiple monitors in nursing stations raises several issues regarding the delivery of nursing care in the ward setting, whether it is in conjunction with or separate from the CCTV system. Every woman knew that she was being monitored by a camera, and that nurses were observing her behaviour to note any potential escalation of risk. It might easily seem to women that they are being tracked due to wrongdoing, creating a jail-like environment which deliberately invades these women's privacy. If women perceive the monitoring in this way, it might cause the development of mistrust of nurses, with such feelings invariably creating a barrier to the development of a strong nurse-consumer relationship, which is generally based on trust (Pinho et al., 2017). This prompted a reflection on what it would be like to offer mental health nursing care both with and without such monitors.

While Rachel did not consider the impact of the CCTV on her offer of care for women with psychosis, she did have some insight into the effect of these cameras in terms of potentially escalating certain psychotic ideas. Rachel's understanding of disorders with psychotic symptoms and her identification of psychotic symptoms in some women suggest that she had a sound basic knowledge of psychosis; however, Rachel also suggested that further in-service training is required as a means of updating nurses' knowledge:

[The in-service training] is not [sufficient]. We have [some] in-service training..., [and] throughout the year we have continuous education that is good, but I think we need to have some updated programmes and [to find out] what is going on in [terms of] the current trends. (p. 5, lines 183-185)

Rachel's view supports the idea of a gap in the in-service training offered by Hospital B in terms of updating nurses' knowledge of mental health nursing, which might impact nurses' understandings of psychosis in their provision of care for consumers with psychosis and related disorders. However, other nurses in Hospital B expressed satisfaction with the in-service training programs offered. Sarah suggested that 'We have enough education...we have nurses' educators here for us' (p. 4, lines 135-136), while Sophia added, 'We have [much] in-service training [sessions] here... we have classes' (p. 2, lines 77-78). The satisfaction with the in-service training reported by Sarah and Sophia can be considered alongside the higher educational qualifications of nurses in this hospital compared with nurses in Hospital A as a means of indicating Hospital B nurses' generally sound understanding of psychosis. An examination of the qualifications of the ten nurses interviewed for this research from Hospital B, as noted in the sub-section on *Nurses' demographics* in Chapter Six, shows that nine of the participating nurses in Hospital B held Bachelor's degrees in general nursing, which require four years of study for general nursing and include at least one course and brief training in mental health nursing. The other nurse was a specialist in Mental Health Nursing, having undertaken intensive training in mental

health nursing at the end of her Bachelor of Nursing degree. This is also supported in Rachel's view about psychotic symptoms and disorders, despite her critique of the hospital's in-service training. In this case, in-service training may still be considered a gap in the service that may need to be addressed, though perhaps with less urgency.

Specifically for Hospital B, nurses' experiences of caring for women with psychosis in the OPDs, which impacted their understandings of psychosis, were also discussed. Daisy stressed that nurses' experiences and understanding of women's situations arose only through checking diagnoses on the electronic system, as the nurses are not permitted to be with the women during their mental health sessions in the clinics: 'We can check [a consumer's] diagnosis [through the electronic system], but we cannot engage with sessions [inside clinics]. I think this is...personal, maybe doctors, psychologists and sometimes [consumers], they do not want that' (p. 2, lines 46-48).

Samantha, from the same clinic, added that her experience of caring for women with psychosis in the OPD was limited to recording their vital signs:

Actually, we do not sit inside [the clinic], we just take the women to the clinic, only [take] their vital signs, and...ask them, 'How are you, are you okay? Normal?'. If she is psychotic, we give her priority [but] then just send [her] to the clinic. In this country, the [consumer] does not allow us to be with the doctor because [if she has much] stress, she does not like to share that with others; [it is] confidential. She does not trust us, even though we do not know the language; they do not allow us, and the families also do not want us to be with the [consumer] inside the consultation room, so we [do not offer] any direct care to these [consumers]. (p. 1, lines 31-37)

Anna justified the limited experience of being with women during clinic sessions based on the limited time available to nurses caused by staff shortages, although she acknowledged this meant that their understanding of psychosis was hampered:

We have a shortage of staff; our role as nurses here is [restricted to] taking the vital signs of the [consumers] and initial assessment. [There] are seven nurses here in total... so the thing is that we have minimal time to be with

the [consumer], unlike inpatient nurses; here we have less time to [know] about the [consumers] and to go with the women and sit with them. (p. 2, lines 69-73)

Daisy's, Samantha's, and Anna's views of their experiences of offering care to women with psychosis in clinics was these were limited to taking readings of the consumers' vital signs (physical care only), and that their understanding of these women's situations was limited solely to their reading of diagnoses on the electronic system. These nurses explained that they did not apply mental health assessments or mental health skills in these clinics, which tended to limit their understanding of psychosis. These nurses' perspectives also reflected the fact that they believed they were not permitted to go inside the clinics with the mental health team for multiple reasons. One reason, referred to by Daisy, was that the psychiatrists or psychologists refused nurses' attendance in these clinics, which might be a limitation of the system or an administrative rule limiting nurses' roles in these areas. Daisy also added that women might not want nurses to enter the clinics; while she did not indicate the reasons for this belief, it may refer to the fact that the therapeutic relationship between these nurses and the women involved are insufficiently established.

This argument is strengthened by considering Samantha's view in conjunction with the fact that consumers do not trust nurses due to the language difference between these nurses and the women with psychosis. As reported in Chapter One, most nurses in all specialties in KSA are expatriates, and the prevalent language used in KSA hospitals is English (Alenezi, 2017; Suliman & Tadros, 2011). However, information about the proportion of KSA and non-KSA nurses working in mental health is not available, nor is information available on the proportions of Arabic and non-Arabic speakers. Therefore, there is an information gap in this area, but based on the researcher's knowledge about the OPD nurses in Hospital B, of the six nurses employed, five were non-Arabic immigrants, while only one was Arabic. The non-Arabic immigrants relied on this Arabic nurse to communicate with most of the consumers

and their relatives, and it was readily apparent that communication between the nurses and consumers was made more challenging due to the language barrier. These nurses were caring for women from a different culture who did not speak English, and the resulting language differences may cause those women to doubt the usefulness of the nurses accompanying them where the latter cannot speak Arabic. Samantha also added that consumers' families often did not want the nurses to be present with the women, perhaps due to cultural misunderstandings and language differences. The final reason for nurses not being able to be with women during their OPD mental health sessions, as discussed by Anna, is the limited time available to these nurses due to the shortage of nursing staff. The limited time available to nurses to provide mental health care for the women is also reflected in the nurses' lack of understanding of psychosis.

The role of the nurses in Hospital B's clinics is simply to record each woman's vital signs before sending her into the clinic for her session, which supports the view that these nurses are forced to adopt a service-based recovery orientation (Schrack & Slade, 2007). This recovery orientation can also be assumed to be based on the nurses' limited adoption of holistic approaches (Schrack & Slade, 2007) when providing care to women. Providing physical care only, as the nurses themselves noted, might be related to the service system, which may be the main source of this approach in nursing care.

In this sub-theme, Hospital B nurses' perspectives on care provision for women with psychosis in KSA were highlighted, in conjunction with their understanding of psychosis. The nurses' lived experiences of offering care to women were explored using the existentials of van Manen (2014), allowing the revealing of the nurses' understandings of psychosis. Many nurses' understandings of psychosis were impacted by their experiences of

relationships with women and their experiences of offering only limited care to women in clinics due to the limited time available, which in turn is caused by staffing deficiencies.

The other perspective considered under this sub-heading was the lived cyborg as defined by van Manen (2014), which was used to understand Rachel's perceptions of how experiences of technology (TV and CCTV) might be related to certain flawed paranoid ideas in women with psychosis. This perception might further indicate that the managers of the mental health ward in Hospital B should carefully consider the impact of having CCTV in the women's rooms, as it may escalate certain psychotic symptoms. More education for nurses might help them to understand and develop therapeutic relationships which could help women with psychosis actively recover, rather than simply monitoring them remotely through CCTV systems.

The lived things lifeworld existential of van Manen (2014) was also used to explore nurses' education and in-service training experiences in terms of the impact on nurses' understanding of psychosis. Some nurses in Hospital B viewed their workplace as nurturing their knowledge of mental health by supporting them with continuous training and education; in contrast, Rachel suggested that the current training was insufficient and outdated. She recommended the provision of more training and education to improve nurses' experience of care:

What we need to know [can come from] that kind of journal presentation...some people who have advanced knowledge can do some presentations especially [on] mental health nursing, what is going on, what is new in our field. Of course, we... [know]...new things, but [we] need more, somebody to share with us...either doctors or highly expert nurses. We would be happy to know what is going on [so to] apply it as new types of management and therapies [emerge to help us] care for our consumers. (p. 5, lines 185-191)

The Hospital B nurses who participated in the study had higher qualifications than the nurses who participated from Hospital A. Moreover, based on the nurses' perspectives in each case, the in-service training and education levels at Hospital A appear to require greater

improvements than those in Hospital B. These variations may support an understanding of why the participating nurses from Hospital A revealed a clearer limited understanding of psychosis than those from Hospital B, such as Rachel, who viewed psychotic disorders and symptoms from a generally rational perspective, despite feeling that she required updated training.

The nurses in Hospital B's clinics affirmed they were not able to support women during their appointments with the mental health team. Their care experience was limited to taking the women's vital signs, and their understanding of psychosis was limited to reading about the women's diagnoses via the electronic portal. Daisy suggested that the nurses in the clinics should strive to understand various aspects of women's mental health more actively: 'For us as nurses, we must know, about what is the case, what is the history, and everything...to know more about unpredictable behaviours' (p. 2, lines 49-52). However, the nurses in the clinics believed that the women and their families did not want them to be present during the sessions with the mental health team and noted that language barriers were an issue.

Improving nurses' cultural competence through training might be usefully considered and addressed by managers in Hospital B as a way to overcome the barriers between nurses and the women in the OPDs and their families, facilitating the creation of a functioning mental health team where the interested parties (both professionals and consumers) come from different cultures (Mollah, Antoniadis, Lafeer, & Brijnath, 2018).

One nurse in the clinics also asserted that the limited time available to nurses to provide mental health care exacerbated all barriers, and that this was due to shortages of staff in the clinics. Her statement highlighted the need for more contact time between nurses and consumers to allow nurses to develop and apply more effective strategies of mental health care (Mistry, Levack, & Johnson, 2015); additional time for care might be offered by an

increase in nurse staffing levels. In addition, Hospital B's mental health clinic managers may need to establish expanded organisational roles for nurses working in mental health clinics to allow them to achieve a better understanding of mental illness and, more specifically, of psychosis.

The next sub-theme examines the nurses' understandings of psychosis through the lens of medication adherence and relapse. These understandings were almost exclusively gained through their experiences of providing care to KSA women with psychosis.

9.2.3 Sub-theme 3: Nurses' understandings of medication adherence and relapse in psychosis

Lived body and lived self-other existentials of van Manen (2014) were used to investigate nurses' understandings of medication adherence and relapse in women with psychosis and their views on how educating women enhanced their medication adherence. Improving medication adherence was identified as one of the domains of nursing intervention for psychosis, as discussed in Chapter Four and as identified in the systematic review by van Dusseldorp et al. (2011). Relapse prevention was also promoted as another domain of intervention for nurses in situations of psychosis, as per van Dusseldorp et al. (2011). When the nurses interviewed for the present study mentioned medication, they generally indicated that they were referring to antipsychotic medications, which are recognised as an essential component in the treatment of psychotic symptoms; in all such cases, adherence to medication is also seen as playing a critical role in preventing costly relapses (Higashi et al., 2013).

Daisy, from Hospital B's clinics, emphasised the offering of medication adherence support through psycho-education for the women involved was a crucial part of her nursing care: 'We must follow doctor orders and [teach] them [women with psychosis] about ... the

medications they [are] taking' (p. 1, lines 29-30). Odeyemi et al. (2018), similarly noted that nurses highlighted the necessity of consumers' engagement in psychoeducation to support medication adherence, and Daisy stressed the necessity of providing psychoeducation to improving medication adherence among women.

Many nurses expressed the idea that their understanding of relapse in psychosis was developed through their experience of nursing women with psychosis. All nurses also linked relapse to medication non-adherence. The reasons for medication non-adherence might be related to insufficient efficacy or intolerable side effects, according to Lieberman et al. (2005), who showed that 74% of consumers with psychosis discontinued medication within 18 months for these reasons. Consumers also refused medication when this was applied by injection, when dosages were increased, or when medication was changed (Farrelly et al., 2014). A lack of medication adherence might also be caused by consumers feeling that medications are being imposed on them, without them being offered any explanations about the purposes of taking the medication, causing them to feel threatened and to question the medication's efficacy (Farrelly et al., 2014). Furthermore, according to Higashi et al. (2013), greater non-cooperation with medication adherence, occurs in situations of increased symptom severity or where there is another reason for lack of insight. Consumers with more severe symptoms are less likely to consider relapse prevention to be an essential issue during treatment (Löffler, Kilian, Toumi, & Angermeyer, 2003).

Majidah from Hospital A mentioned that, in her experience, women's refusals to take medication were the main cause of relapse: 'Most of the consumers' relapses occur because of their resistance to ... taking medications' (p. 2, lines 68-69). Rabab similarly expressed an understanding of relapse as being most related to medication non-adherence: 'Some [women with psychosis] have relapses for many causes...some [stop] medication once [the woman

with psychosis] feels she is recovered for two or three days. Another mixes the medication [intake times], some [miss doses of] medication' (p. 2, lines 53-55). Majidah and Rabab presented their understandings of relapse in women with psychosis by relating such relapse to observed medication non-adherence. While Majidah and Rabab did not discuss the reasons for medication non-adherence explicitly, the research supports their perspectives on reasons for medication non-adherence. Majidah and Rabab generally displayed a solid understanding of relapse based on their experiences of providing care.

Other nurses from Hospital A talked about their understanding of relapse based on family misunderstandings of medication leading to them not supporting women's adherence to medication regimes, therefore triggering relapse. An example was offered by Hafsa, from Hospital A, who talked about family dissatisfaction with medication side effects:

The cause of the relapse for consumers may often be that the family is not satisfied with the medication; [they are] convinced that the consumer is sick but not satisfied with the treatment because the medication has side effects. For example, some medication causes sleep, so the mother, father, or brother stops this medication for that reason, or their daughter [woman with psychosis] cannot sleep, so she takes the medication irregularly, which is the [main] reason for the relapse. (p. 1, lines 35-39)

Fadwah mentioned that, based on her experience, when a family struggles to understand a woman's illness, they are unlikely to support her medication, as this is likely to cause her to be non-adherent with her prescribed medication regime, she is then more likely to suffer a relapse and be admitted again:

The woman's family cannot understand the nature of her illness, so they cannot deal with it properly. As a result, she returns to the hospital with relapse as they do not give her the medicine [and she must be] admitted to the hospital once again. (p. 1, lines 13-15)

Sabah stated that, in her experience, relapse is often related to family lack of understanding of the importance of adherence to medication regimes:

Woman discharged from hospital when she is recovered, yet her relapse is usually because of carelessness and a lack of awareness [among] her family. Sometimes, there could be no one qualified in her house...to take care of this woman and give her the medication on time; this is the most critical factor in treatment. (p. 1, lines 29-32)

For all nurses their perceptions of relapse in psychosis concerned the consumers' families, suggesting that the latter played a highly significant role in women's relapses. The family is viewed as a factor in most relapse situations, particularly regarding promoting or enabling non-adherence to medication. The nurses' views support research suggesting that the family environment is the most critical determinant of relapse and medication adherence, as families either support or neglect consumer needs (Rahmani, Ranjbar, Ebrahimi, & Hosseinzadeh, 2015). According to these nurses' views, family lack of support, based on misunderstandings of psychosis and ignorance of the importance of medication adherence, prevent adherence to medication for many women.

The nurses' perspectives in this sub-theme addressed their understanding of medication adherence and psychosis relapse based on their experiences. Through the use of van Manen's (2014) lived body lifeworld existential, nurses' understandings and perspectives about relapse and its relationship to medication adherence were highlighted. All participating nurses linked relapse to medication non-adherence, and many emphasised the role of family misunderstandings of psychosis and medication in hindering medication adherence and facilitating relapse. Fadwah added a comment on what a consumer's family needs to do to prevent relapse: 'We want the consumers' families to take good care of the consumers. [A] woman leaves the hospital in good condition, so she should not return with a relapse' (p. 2, lines 69-71).

The lived self-other of van Manen (2014) was used to explore Daisy's view about how she needed to relate to the women with psychosis by providing psycho-education as part of her care. Some of the other nurses' views and ideas imply that broader, family-based, psycho-

educational interventions are necessary to encourage adherence, and that these should be an integral part of nursing care for women with psychosis. Anna, from the OPD at Hospital B, highlighted this idea that nurses should offer psychoeducation to the consumers' families regarding the medication regimes required to prevent relapse:

For those kinds of [consumers with psychosis], the first person to support them is the family, regarding the medications, because the [consumers] just come here [to the clinics] for follow up; you know, you cannot continuously guide them, so [any support] will be with the family.... Most of them [consumers] are functional [in life] but sometimes, we cannot save them [from relapse]. They need to have proper medication ... [so] that they will not relapse. We need to educate the family. They need to monitor the medication for the [consumers] especially [consumers] with psychosis, because once they miss their medication, there may be a [consequential] relapse. (p. 3, lines 113-119)

Anna indicated that the family must be mainly responsible for each woman's care to prevent relapse. This supports the report by Li and Arthur (2005), which noted that, due to the trend of reduced hospitalisation durations for consumers with mental illnesses, families now have the primary responsibility for consumer care, and therefore play a significant role in any relapses. This idea of family responsibility informs Anna's emphasis on the need for psychoeducation for families.

Catherine, from Hospital B's inpatient ward, expressed the view that nurses should offer psychoeducation to both women and their families, particularly in terms of medication and illness after discharge:

There are no communications outside [of the hospital] ...only [the doctors] can communicate with the [consumers] when they are discharged.... When [the family] call [after woman's discharge], [saying] 'she [woman with psychosis] is doing [such a thing], what should I do?' We should advise them [family] about medication [or] any problems ... we should give advice and health teaching, and we [should] call [to] advise [the woman with psychosis] if she should go to the emergency room or clinic... we need to be updated with the [consumers' situations]. (p. 2, lines 58-68)

Afrah, from Hospital A, similarly proposed adopting nursing interventions to prevent relapse, supporting Anna and Catherine's views of the necessity of applying psychoeducation to the family in terms of both illness and medication:

We want to meet the family to [let them] know the woman's case well; we would like to educate them and make them aware of the consumer's illness, [and] they should accept medication [advice] through the nurses along with the doctors. [Currently,] the family only communicates with the doctors. We want to communicate with a woman's family, to know what happens with the woman. We should have well-educated nurse links with the families and the other nurses of the second shift, which would reduce relapse [occurrence] in consumers.... [Currently,] we are not allowed to communicate with the families. (p. 2, lines 45-52)

Anna, Catherine, and Afrah all recommended family psychoeducation for relapse prevention. Family psychoeducational interventions were also reported as efficient by Rahmani et al. (2015), who suggested that such interventions reduced the risk of relapse for consumers with schizophrenia, based on them enhancing medication adherence in the first year after hospital discharge. The nurses' recommendations for prioritising provision of this psycho-education in this study accord with the study of Moe, Kvig, Brinchmann B, and Brinchmann BS (2012), included in Chapter Four, who suggested that nurses' interventions with consumers experiencing their first episode of psychosis should have the goal of facilitating non-scheduled and indirect network discussions with consumers' family members in order to help prevent relapse by acquiring supplementary information about consumers such as symptoms and medication adherence. Knowing more about these aspects would also enable nurses to give consumers and their families targeted psycho-education on managing specific issues, thereby decreasing the risk of relapse (Moe et al., 2012).

The nurses' inability to provide comprehensive information about the illness and available medication or to engage effectively with families may be seen to demonstrate that both facilities offered mainly service-based recovery (Schrack & Slade, 2007) in nursing care. The

nurses' recommendations that they be permitted and facilitated to be more involved and engaged with families through psycho-educational interventions may be hampered by hospital policies limiting nurses' communication with, and therefore education of, the women's families. Hospital managers should consider removing such restrictions to facilitate nurses' communications with families both in the hospitals and after discharge.

Furthermore, as presented earlier in Chapter Two about the expanded roles of mental health nurses, competence in providing psycho-educational intervention requires specialised education for nurses (Morse & Procter, 2011). Therefore, it is recommended that nurses be prepared by being given training on the knowledge and skills required to strengthen such communication with families alongside the required targeted education on medication adherence and relapse symptoms.

Overall, examining nurses' understandings of psychosis when providing care to KSA women as a theme allowed several rich perspectives to emerge, which taken together highlighted three sub-themes: *Hospital A nurses' understandings of psychosis*, *Hospital B nurses' understandings of psychosis*, and *nurses' understandings of medication adherence and relapse in psychosis*. Hospital A nurses' views overall demonstrated a general lack of understanding of psychosis, which may be presumed to be due to their lower levels of educational qualifications than Hospital B nurses. Another reason might be the limited in-service training and education offered in Hospital A, as this was also highlighted in these nurses' perspectives. Many nurses in this hospital recognise they needed education and training before they took up their posts and required adequate in-service training to enrich their understandings of psychosis.

In Hospital B, the nurses working in the OPDs stressed their inability to provide mental health care due to not being allowed to accompany the women during their sessions in the

clinics. This limit to their experience might lead to a certain lack of understanding of psychosis, and managers of these clinics may need to consider the expansion of the roles from general to mental health nursing roles in these clinics to help nurses develop their understandings of psychosis as a precursor to providing better care to women.

The final sub-theme focused on nurses' views of their understanding of psychosis in terms of medication adherence and relapse. All the nurses emphasised that relapse mainly occurred due to medication non-adherence, though many nurses also highlighted the role of family misunderstanding about psychosis and the impact of medication non-adherence and its negative effects on relapse for some women. Many nurses recommended that they be assisted to provide educational interventions to the women's families, therefore allowing them to support the women's medication adherence to prevent relapse in an additional way.

All three sub-themes suggest that both hospitals' services currently focus on service-based recovery approaches (Schrang & Slade, 2007), with many nurses applying solely physical, rather than holistic, care. The nurses' awareness of the lack of psycho-education for the women and their families and of poor communication between nurses and families was a further indication of the limited user-based recovery approach used by nurses (Schrang & Slade, 2007). The recommendations previously offered in this theme about empowering nurses through education and training and reviewing policies to expand nurses' roles to facilitate engagement with women and their families, are necessary to address the gap created by the present service-based recovery approach to nursing care.

The second theme in the overarching theme of nurses' understandings and emotions in nursing care was the *emotional labour experienced when caring for women with psychosis*, which is discussed in the next section.

9.3 Theme 2: Emotional labour experienced when caring for women with psychosis

All nurses' views in this theme were analysed with the support of van Manen's (2014) lived body existential, allowing a deeper understanding of nurses' personal and emotional experiences. Further exploration using the other lifeworld existentials proposed by van Manen (2014) was then undertaken, with several experiences of emotions generated by caring for women with psychosis, work situations and concerns, and nurses' reactions to the limited time available to them to provide care to women due to staff shortages triggering a further investigation. This theme is divided into two sub-themes: *nurses' emotional experiences related to staffing concerns* and *experiencing transference and countertransference when providing care*.

Emotional labour refers to the effort required to suppress one's own emotions as a means of caring for others more effectively; the levels of such effort are usually high among nurses, who experience daily stress in their interactions with consumers with complex needs (Hercelinskyj, 2010). In the present study research, many nurses reported expending great effort in caring for consumers, which affected the nurses emotionally.

9.3.1 Sub-theme 1: Nurses' emotional experiences related to staffing concerns

This sub-theme was identified as the first sub-theme in the consideration of nurses' experiences of emotional labour. Van Manen's (2014) lifeworld existentials were used to understand these nurses' views, highlighting their experiences of stress based on staffing situations which raised concerns among the nurses. With many nurses, their experience of offering emotional labour was further impacted by the additional experience of relationships

with others and the limited time available to them to provide care. In this subtheme, the staff concerns most strongly represented in nurses' perspectives included shortages of staff, high rates of absenteeism, and excessive sick leave, all of which increased workloads, a problem compounded by cases where nurses were not able to adhere to their job descriptions and roles.

Under-staffing was a primary source of stress for nurses in both hospitals. Rebecca, from Hospital B, indicated that staff shortages increased nurses' emotional stress and adversely impacted their capacity to provide care to women with psychosis. She stated:

[There is a] lack of staff here, a lack of support; we are short of the staff here, and we are overburdened, so we cannot attend all the [consumers] at one time. Sometimes we have frustrations, and sometimes we are stressed from the [consumers]...our families are too far [away, overseas], and we become stressed...when we [experience such] stress, I am sure we will not care for [the consumers effectively]. (p. 2, lines 55-58)

Rebecca mentioned that nurses experienced stress due to nursing staff shortages; in particular, they could not attend to all their consumers, which impacted the care provided for some women. The most important reasons for nurses' work stress were jobs not being completed on time for various reasons, including staff shortages (Kane, 2009), and this was highlighted as a source of emotional stress by Rebecca. Moreover, she stressed that this experience adversely impacted the care provided to the women. This is supported by the American Psychiatric Nurses Association (2012), when nurses must tend to too many consumers due to staffing shortages, the potential for adverse care outcomes increases.

Ahd in Hospital A suggested that emotional stress is related to long working hours and to high workloads. She explained that absenteeism and sick leave were the main reasons for the increased workloads. She said:

I think the nurses' numbers are [theoretically] adequate, but it depends on the attendance rate; I am one of [those who do not always attend].

Sometimes, under the stress of long working hours and consumers [work stress], I feel psychological stress and decide not to work the following day. ... today, there are three shifts, and if you reviewed the schedule, you would find that the number of nurses is [theoretically] adequate, but [the actual situation] is again related to absence and leave. Sometimes many nurses have days off, and therefore we do double work. (p. 2, lines 67-72)

Ahd's view highlights the heavy toll of emotional labour experienced by nurses who face additional workloads due to other nurses' high absenteeism rates and sick leave. A study by Shirey (2006) reported that stress in nurses impacts their health and increases absenteeism; the further stress of increased workload following nurses' absences, as seen in Ahd's perspective, has a knock-on effect on the remaining nurses' health, and leads to their having to take sick leave in their turn, creating a negative cycle. This circular problem highlights the risks of increased stress due to increased work burdens and potentially increasing absenteeism, which might compromise the quality of the care offered. In terms of the original reason for increased absenteeism and sick leave among nurses, Ahd's perspective on this was discussed in the previous chapter, where she noted the lack of food facilities at Hospital A caused nurses to experience exhaustion, leading to nurses taking absences or going on sick leave. Ahd also noted that, in cases of absenteeism, the attendant nurses are required to do more work, suggesting that no replacements for absent nurses are provided; this reveals a gap in the management of nursing staff in the ward.

Malak, from the OPDs at Hospital A, described her previous experience on the inpatient ward in a manner which indicated that inpatient nurses experience stress due to having limited time to provide care due to the lack of nursing staff. However, work was also allocated in defiance of nurses' job descriptions and unsuitable distributions of roles occurred, and the ensuing stress adversely impacted the provision of nursing care:

Most of the time, we suffered from a lack of nurse numbers, but not in the clinics. When I was working in the inpatient ward, there was an apparent lack of nurses and job description [adherence]. No one could keep to her job description. Some nurses worked as health assistants or guards because

sometimes guards were absent. Nurses suffered from [additional] pressure imposed on them by doctors as well, because they assigned nurses to other work, [taking away] time [that should have been] devoted to the consumers. This waste of time affected the consumers at the end of the day. (p. 2, lines 60-66)

Malak clarified that the nurses in the inpatient wards experienced emotional stress due to having limited time to provide care and a lack of staff and nurses pushed to not abide by their job descriptions and roles. Malak indicated that some nurses experienced stress due to psychiatrists assigning nurses to work on tasks not directly related to nursing. This might suggest that such nurses hold traditional views of doctors' powers, making them act as though they were subordinate to the doctors, doing whatever the doctors ask (Mckay & Narasimhan, 2012). This lack of focus on their nursing' roles and the performance of extra work outside their discipline adds additional stress to nurses, and such overwork also reduces the time available to focus on and care for women with psychosis.

The nurses' views in this sub-theme reflected the emotional experiences emerging from nursing staff concerns arising while offering care to KSA women with psychosis. Staff concerns represented in these views included staff shortages, high absenteeism rates and excess sick leave, all of which were seen to increase workloads, together with violations of job descriptions and roles that affected nurses' everyday activities. Van Manen's (2014) lifeworld existentials were used to reveal nurses' views on their staff concerns and situations, which were in many cases tied to the limited time available to provide care. Some nurses also discussed their relationships with others as being linked to staffing concerns, which affected them emotionally by increasing their stress.

Nurses' experiences of additional emotional labour and stress caused by short staffing led some nurses to recommend that their hospitals should employ more nurses. Saleha from Hospital A stated that 'The hospital should offer more employment for nurses to overcome the ... low numbers, as some cases need close monitoring' (p. 3, lines 102-103). Increased

staffing is seen as having the potential to decrease nurses' stress and increase the quality of nursing care; as Daisy from Hospital B emphasised, 'We need increases in the staffing of nurses, [to provide] good quality nursing; otherwise, how can we [provide good care] if we are stressed?' (p. 2, lines 81-82). Saleha and Daisy reflect the perceived need to decrease nurses' emotional stress by ensuring adequate staffing, and this is seen to allow them to provide better care. According to Kieft, de Brouwer, Francke, and Delnoij (2014), adequate staffing levels allow consumers' needs to be met more consistently. Finally, the issue raised by Ahd regarding increased absence and sick leave suggests that nursing managers should be more aware of nurses' experiences of emotional stress due to high workloads, as overwork increases nurses' stress, potentially worsening future absenteeism and further reducing quality of care.

In this sub-theme, the increased emotional labour of nurses due to staffing concerns during their provision of care to KSA women with psychosis was revealed; in the next sub-theme, nurses' experiences of transference and countertransference are considered.

9.3.2 Sub-theme 2: Experiencing transference and countertransference while providing care

This sub-theme was identified based on nurses' perspectives on their feelings and responses through the lens of examples of transference and countertransference experienced by nurses while caring for women with psychosis. Previous studies on mental health nursing have identified that caring for mental health consumers can be emotionally upsetting (Basson, Julie, & Adejumo, 2014). Similarly, in this research, the nurses reported frequently experiencing negative feelings, both those arising tangentially from and those directly related to their care for women with psychosis. They also discussed how they try to cope with and respond to these feelings. Many of the feelings and responses identified from the nurses'

views reflect the psychological mechanisms of countertransference and transference, allowing these constructs to be investigated in further detail to form a framework for the development of a deeper understanding of nurses' feelings and responses. In this sub-theme, therefore, the nurses' experiences of transference and countertransference are illustrated and linked to their experience of emotional labour, which in turn reflects the emotional burdens they experience during their offering of care to women with psychosis and the efforts required to bear those burdens and still provide consistent care. This sub-theme emerges from the use of van Manen's (2014) framework to analyse the nurses' experiences specifically in terms of their experiences of transference and countertransference as linked to their lived body and lived self-other.

The term transference, derived from the verb *to transfer*, emerged early in Freud's thinking and writing, appearing initially in 1888 (Freud, 1892). In the therapeutic context, transference occurs where 'The impulses and phantasies which are aroused and made conscious during the progress of the analysis...replace some earlier person by the person of the physician' (Freud, 1953, p. 116). The term countertransference was later defined by Freud (1957) as arising from professionals' responses to consumers' influences on the professionals' unconscious feelings. In terms of mental health nursing, both transference and countertransference may create issues for nurses (Ens, 1999), as professionals experiencing countertransference may undergo a range of emotional responses, such as extreme sadness, which may be triggered by caring for a consumer with severe mental illness (Schaeffer, 2019). Jones (2005) highlighted the relatively high incidence of transference and countertransference in nursing relationships, noting that this may incorporate many contradictory aspects such as strong feelings of affection or disaffection, difficulties in setting limits or the creation of over-rigid boundaries, a desire to please or to avoid particular consumers, feeling either exceptional or insignificant, feeling over- or under-engagement with consumer care, feeling marked comfort or

discomfort with a given consumer, or having positive or negative preoccupations with a consumer to the extent that power struggles may emerge (Jones, 2005, p. 1183).

Several possible explanations for and factors leading to transference in the health environment were noted by Hughes and Kerr (2000) and Turabian (2020), including the fact that frequent contact with health facilities or with health professionals increases the likelihood of transference in many consumers. This means that in any therapeutic facility in which a consumer is seen frequently, some consumers are likely to develop transference relationships with one or more professionals (Hughes & Kerr, 2000; Turabian, 2020). The potential for frequent changes of professionals across visits may, however, cause consumers to either displace their feelings onto the facility as a whole or fixate on an individual professional, processes which may manifest as unpredictable or frustrating behaviours from an external perspective (Hughes & Kerr, 2000; Turabian, 2020).

Countertransference, however, is most likely to be present where a professional's needs have not been met in the past. For example, professionals with dominating parents tend to assign domination roles to their consumers, particularly older consumers, in the hope of addressing their dominance issues by caring for those individuals, which may meet the professional's deep-seated need to express self-determination (Schaeffer, 2019).

It is a particularly interesting part of the present study to explore the responses of the nurses caring for women with psychosis in terms of any transference or countertransference experienced. By examining nurses' stories carefully to identify such feelings and responses, both the positive and negative aspects of how human beings seek out relationships can be examined, which in turn reflect both the positive and negative aspects of sincere human interest, caring, and concern (Margarian, 2015). Transference and countertransference may both make professionals' work extremely successful and diminish or even negate

professionalism; where the latter occurs, this is generally to the detriment of the consumers involved (Schaeffer, 2019).

The nurses' views clearly reflect the existence of transference and countertransference in their care for women with psychosis. Fadwah and Majidah focused most intently on their feelings of sadness and pity. Fadwah discussed such feelings in terms that might indicate the existence of countertransference, which may be assumed to be a response to some women's transference: 'As for feelings of sadness, we feel pity for [the woman with psychosis] and wish that her family did not neglect her like that' (p. 2, lines 43-44). Majidah discussed a broader range of feelings, though many of these may still be linked to the women's transference:

I may feel upset, cry, get nervous, feel pity ... [but I do] my best for [each woman with psychosis], mainly if something terrible happened to her.... I never feel disgusted because maybe someday I could be in her place. [Nurses'] feelings are the most important things. When I feel pity for a woman, I help her as much as possible according to her situation. If her family left her, I feel pity, get upset and cry for her... one...consumers... family...died in an accident. Therefore, sympathy remains and cannot be compensated [for]. (p. 2, lines 73-80)

Rabab further implied the existence of countertransference by discussing targeted feelings of disgust that arose when caring for certain women with psychosis: 'I feel disgusted, but not for everyone; it depends on their [women with psychosis] characters' (p. 3, line 130). Similarly, Sophia, from Hospital B, highlighted the existence of countertransference in terms of being *fed-up* when offering care to women in the long term: 'As human beings, we have our moods; you sometimes become fed-up [taking care of the consumers], but I always remind myself, I am a mental nurse, ... I need to help the [consumers], I need to listen to them' (p. 2, lines 48-50).

Further negative emotions offered by Majidah, and Rabab illustrated nurses' fears while providing care for women with psychosis, which tend to be related to nurses' earlier

professional experiences of caring for women with psychosis who demonstrated aggressive behaviours. Majidah offered a specific example that further highlighted the impact of exposure to aggression: ‘As for fear, sometimes we feel fear, but [we] try to control it. We should be alert [though] because we have been hit and threatened’ (p. 2, lines 84-85). Rabab similarly noted that her fear when caring for some women arose from her previous experiences with unanticipated aggression:

I [also] have feelings of fear because of the situations I [have seen] in this place. I had an [incident with] a person [who had not shown] any signs that she [might] attack: suddenly, she was like a beast, and this makes me afraid of the consumers. (p. 3, lines 123-126)

Majidah and Rabab’s views illustrate that the nurses’ fears are generally related to earlier professional experiences of providing care for women with psychosis. This is relevant, as countertransference feelings experienced by professionals towards consumers may be based either on the consumer’s current behaviour or the professional’s previous professional and personal experiences (Oliver, 2017). Ramalisa, du Plessis, and Koen (2018) suggest that nurses’ frequent exposure to consumers with violent and aggressive tendencies increased their negative feelings during the process of offering care and increased the challenge to such nurses of coping with those feelings, potentially triggering the emergence of countertransference as a coping mechanism.

The feelings which emerge from countertransference may lead to distinctive yet conflicting responses, with some nurses offering extra care to consumers who trigger these coping mechanisms (Eren & Şahin, 2016). Such over-engagement or involvement is often seen as being related to sympathy, and this can be used as an alternate term for those forms of countertransference that arise from over-identification, over-involvement, or an emotional attachment (Guerrero, 2019). An example illustrating this was offered by Afrah, from Hospital A, who expressed the idea that her feelings towards women led her to offer more

care to them: 'I feel sad for them [women with psychosis], and this feeling makes me want to help those consumers as [well as] I can until they recover. I pity them' (p. 1, lines 35-38).

Afrah's experience of feeling sadness and pity for these women can be accurately described as sympathy aroused while providing care. When sympathetic feeling drives nurses to provide more care, this might challenge some women's empowerment who have lower self-control, self-help, and independence. This perspective may be read to suggest that Afrah provides care using only a service-user based recovery approach (Schrank & Slade, 2007).

More concerning responses that may arise from cases of countertransference include active neglect on the part of the professional (Stefana et al., 2020). These were exemplified by both Manahel and Rabab, who expressed various negative responses toward caring for women with psychosis. Manahel mentioned that she 'ignore[s] a woman who is talking to herself and screaming' (p. 1, line 19). Although Manahel did not explain why she ignored women, this behaviour may arise from her frustration at her lack of sufficient knowledge or training, which would prevent her from communicating effectively with women with hallucinations. Rabab further reported that she offered increased care to some women while ignoring others: 'Here, we have someone who is noisier than [any] consumer...so, sometimes I respond, and sometimes I do not until she becomes calm.... I may be upset with some consumers, not others' (p. 3, lines 91-110). A lack of engagement with consumers may also result from frustration among nurses with regard to issues of communicating with consumers, particularly where consumers are unwilling to adhere to treatment; such issues make it difficult for professionals to remain motivated to provide care (Sibiya, 2017).

Rabab, Daisy, and Madison all noted further issues related to transference and countertransference, with Rabab reporting experiencing multiple feelings commonly associated with countertransference, such as annoyance and anger, when caring for certain

women. She also noted that she finds it challenging to manage provocative behaviour, which may further be assumed to represent transference:

Some consumers... those led us to go crazy...like ... another [woman with psychosis] ... when you see her, it is impossible not to speak [with her and she will] anger you. This anger affects her care badly, [though] the consumer has the right to receive care. For example, when you ask her to [attend to recreational activities] at the defined time, she answers that she does not want to [attend] at that time, [as the woman] is changing her clothes now, or that she [did it] yesterday. Then, at 2 p.m., with half an hour before the end of the shift...she asks to [participate]...sometimes she [does this] deliberately and sometimes not.... Do you not consider this a provocative person? (p. 3, lines 112-123)

The countertransference experiences represented by Rabab's reported feelings of annoyance and anger generally relate to difficulty in managing consumers with severe mental illnesses (Schaeffer, 2019), a process made more complex by trying to manage consumers' transference to nurses in some situations. The nurses in Ramalisa et al. (2018) reported similar difficulties with staying calm and positive when providing care for consumers with mental illness, which is generally attributed to illnesses being challenging to manage. Similar ideas were expressed by Daisy, from Hospital B, who noted she disliked working with some women in a manner that strongly implied the existence of countertransference arising from her difficulties in managing women's transference reactions, including their resistance to admission, and crying:

Sometimes, there are some [consumers] I do not want to be with at all: sometimes they do not want to be admitted, and in case of admission, they want to run. They do not want to listen; they are just crying. In that situation, we handle them here, [but] really, it is tough to [manage] that [consumer] at that time. (p.1, lines 34-36)

Rabab and Daisy discussed their responses to women reacting in antagonistic manners that represent transference in a similar manner to the ways Hilz (2004) discussed which emphasise consumers' excessive dependency and demanding behaviours that express angry, bitter, or contemptuous feelings towards a particular nurse or nurses. These behaviours often

arise from the consumers' insecurities as expressed in their attachment to nurses (Martin, 2018), causing discomfort to both parties. Women with psychosis, as discussed by Rabab and Daisy, frequently express such feelings negatively, and the nurses are consequently provoked to counter or respond from a place of anxiety despite remaining concerned with taking care of the women involved in terms of both their professional obligations and human fellow-feeling. The nurses are conflicted due to their natural instinct to avoid consumers who make them uncomfortable, based on the inherent discomfort of being the object of negative expression of emotions (Aiyegbusi & Kelly, 2015).

Those nurses who shared experiences where they had ignored communication with certain women appear not to realise that communication with consumers is crucial if nurses are to provide the necessary care and support. Some authors have adopted the premise that neglecting communication with consumers constitutes a lack of respect (Kwame & Petrucka, 2020), which offers further insights into Rabab and Daisy's views, and which might highlight the negative expectations of these nurses' work cultures. Such work cultures, as noted by Fincham and Emery (1988), demand that when consumers seek professional help, they accept the care offered without question; consumers who do not follow the implied rules of care, particularly those who reflect transference, are perceived as causing the health care professionals additional difficulty, and are labelled as troublemakers. These consumers are also seen as presenting challenges to the provision of care when their behaviours contravene the norms of health service culture; this can result in professionals developing countertransference based on their feelings of helplessness and inability to offer what they see as appropriate care (Fincham & Emery, 1988). Such countertransference may also challenge their experience of autonomy, competence, and purpose (Fincham & Emery, 1988), which may help to explain why Rabab and Daisy reported responding in such negative

manners to women who did not follow the rules of care or adhere to the expectations of the hospital culture.

Madison shared further insights into the struggles that she and other nurses experienced due to emotional reactions to women with psychosis:

For us as nurses, we need more understanding [of women with psychosis]
...so we should not be harsh to them, we should understand [the illness]
very well....we should not return [aggression] back to them ...but
sometimes, we are human, sometimes we raise our voice; that is normal
[under] stress because you want [to take] care of them. (p. 1, lines 18-22)

Madison displayed insights into the preferred response when communicating with consumers, based on her understanding of women with psychosis and a focus on not responding in a harsh or aggressive manner. However, she also shared a potential sign of countertransference, the raising of nurses' voices towards consumers, which she viewed as a natural response to the stress she and other nurses experience. Johnsson, Boman, Wagman, and Pennbrant (2018) argued that nurses' use of moderated voices and soft tones throughout communications with consumers demonstrate respect and care for consumers; raised voices may be seen as unacceptable professional behaviour.

It is notable that most nurses who recounted experiences potentially linked to countertransference were from Hospital A, rather than Hospital B, which may reflect the lower levels of mental health education and training there (see the *Nurses' demographics* Sub-section in Chapter Six). It is also clear from the nurses' views that their feelings generated while caring for women with psychosis are reflected in their responses and the ways in which they relate to the women involved. These perspectives reflect two of van Manen's (2014) lifeworld existential experiences, the lived body and the lived self-other. These embodied experiences further highlight the work culture in which these nurses operate, which hinders nurses from addressing or acknowledging their feelings and responses as being

negative. There appears to be no awareness of the high probability or potential adverse effects of transference and countertransference, which may cause consistency of care to be impacted with further negative consequences. Therapeutic relationships with consumers who have mental illnesses are most effective when they are consistent, and consistency requires the maintenance and awareness of appropriate boundaries; these are also essential in developing trusting and safe therapeutic relationships (Psychodynamic Diagnostic Manual, 2017). Consistency can also help professionals to prepare for transference and countertransference responses more effectively (Day-Calder, 2016). However, none of the nurses' views in this sub-theme acknowledged the idea of consistency as an important factor in the care of people with psychosis, and the resulting inconsistent care may demonstrate a lack of awareness of transference and countertransference that may lead to further negative consequences and impact the prevalent mental health nursing work culture.

Both positive and negative feelings may occur without mental health nurses' active awareness according to Jones (2004). The most crucial task in nursing care in terms of managing transference and countertransference may be to recognise and understand all of the positive and negative feelings that may influence the nurses' attachments to, and relationships with, consumers (Jones, 2004). If the emotional burden carried by nurses in their practice is acknowledged and accepted, and the potential for both transference and countertransference recognised, resolution of any issues caused is likely to be both more rapid and more manageable. It may be worthwhile to identify ways in which nurses can be assisted to become more mindful of their experiences as they are linked to transference and countertransference; such a development might also allow them to more effectively access constructive possibilities for professional development and offer further therapeutic gains for consumers (Jones, 2005). It would therefore be advisable for nurses to be encouraged and taught how to perceive and accept countertransference as a welcome challenge and as a

formative part of their professional work with consumers, including acknowledging their own difficulties and frustrations with particular consumers (Guest, 2019). Such acknowledgment would require nurses, as professionals, to move beyond their current systemic lack of acknowledgement of countertransference to acceptance, allowing them to become open to challenging their own instinctive responses.

The professional's first task in this area must be to identify signs of transference as early as possible, rather than seeking to avoid acknowledgment of its existence (Noorani & Dyer, 2017). Turabian (2020) also indicated that health care professionals could manage transference more effectively by actively working to improve their relationships with consumers and by prioritising reliability and honesty in their communications. Health professionals must also maintain professional boundaries and place clear limits on interactions with consumers in their care. However, maintaining these professional boundaries while empathically responding to consumers in order to prevent them from feeling rejected or abandoned can be challenging, and errors in this process might risk premature termination of the caring relationship (Noorani & Dyer, 2017).

Where consumers are able to understand the idea of transference, health professionals may be wise to discuss this matter openly with them (Cowan, Welton, & Kay, 2016). Encouraging consumers to talk comfortably about transference is often a helpful way to allow them to take responsibility for and better manage their personal feelings; this also allows the professional involved to gain a clearer understanding of the complexities of their underlying relationships (Cowan et al., 2016). However, this may not be able to happen immediately or may not be possible at all for some consumers, although one way to facilitate such discussions is to explain to consumers that discussing their relationships with others can help professionals learn more about their thoughts and feelings (Noorani & Dyer, 2017). It is essential, however,

that consumers be made aware that no feelings are considered taboo and that the professional will be comfortable discussing and trying to understand any responses; otherwise, the consumer may feel embarrassed, rejected, or negatively judged, which would impede communication (Golden & Brennan, 1995). Kerr (1999) supported this with the idea of team discussions to clarify difficulties in consumer care related to shared care relationships. These discussions allow several health professionals working as a group to contribute to the development of an understanding of a given consumer's transference, whether such transference applies to the whole health care team or an individual health professional who is a member of that team (Kerr, 1999).

In managing experiences linked to countertransference, Katz and Johnson (2016) emphasise the importance of reflection on countertransference in health professionals' development based on questioning the professional's feelings and motives; in particular, it is crucial to recognise that every person has individual blind spots. Appropriate physical and psychological support in the work environment might include developing a team spirit which promotes opportunities for nurses to self-reflect and allows them to be debriefed by others and to access relief through humour (Brennan, 2017). Furthermore, health professionals should understand and be aware that, just as staff are affected by consumers, consumers are affected by staff behaviours and attitudes, causing consumers to frequently have strong feelings towards staff (Turabian, 2020).

In order to enable them to manage the feelings and responses generated and amplified by transference and countertransference, supporting nurses in the development of better coping mechanisms and strengthening resilience are essential aspects of the overall provision of mental health care (Ramalisa et al., 2018). In the present study, the experience of caring for women with psychosis generates feelings of disdain for specific consumers in some nurses,

such as Daisy. Strengthening nurses' resilience could assist such nurses to learn to sustain themselves in the face of adversity without resorting to hostility (McGowan & Murray, 2016), potentially helping them manage countertransference issues more effectively.

Transference and countertransference, as represented by the negative feelings and responses discussed by some nurses in this study, can also be addressed by introducing strategies to help nurses cope more effectively with negative feelings and responses. Such strategies include developing effective communication skills, increased health education, and the provision of explanations during nurses' interactions with consumers with mental illnesses during their clinical supervision periods, all of which can enhance nurse-consumer relationships and help nurses better understand, and meet, consumer needs (Ramalisa et al., 2018). These strategies could be usefully used by nurses such as Manahel, who appears to require additional coping and resilience mechanisms to help her avoid adopting negative communication approaches towards women with hallucinations, for example. Such nurses might instead be encouraged to approach women with the aim of assisting them in developing an understanding of hallucinations. However, from an ethical point of view, it is vital to orient nurses to the central idea that communication should be built on trust and respect (Moreno-Poyato et al., 2016). Wholehearted adoption of this view could allow nurses with blurred boundaries, such as Madison, to develop their abilities to select more ethical responses when they face difficulties in caring for women with psychosis.

The nurses' embodied experiences represented by reactions to fear related to nurses' earlier experiences, particularly when such experiences occurred at the beginning of their careers, indicate that many of these nurses started caring for women with psychosis without sufficient prior training. This can be related to the previously identified sub-theme of *Hospital A nurses' understandings of psychosis*, exemplified by Madeeha, from that hospital, who

reflected that she was afraid of caring for women with psychosis at the beginning of her career. This emphasises the dilemmas faced by nurses in their attempts to care for women with psychosis while trying to regulate their own strong emotions such as fear.

Another reflection on the experience of fear is linked to the lack of healing spaces in mental health facilities. Referring to the previous chapter's discussions of lived space and how nurses view their work environments as not helping to self-care, such negative perceptions may easily be linked to feelings and responses of countertransference. For both the nurses and the women with psychosis, the unfavourable atmosphere caused by these facilities may exacerbate fear or promote aggression, emphasising that these hospitals need to build healthier workspaces to enhance nurses' self-care opportunities to minimise the negative consequences of transference and countertransference. Furthermore, as part of ongoing efforts to better manage transference and countertransference, ways should be found to reduce the effects of various work and environmental stressors. Where relationships or circumstances between consumers and nurses seem particularly difficult to resolve, taking the opportunity to introduce a different nurse may be beneficial; however, this is only possible where adequate staffing exists (Jones, 2005).

In other situations, a facility policy may be sufficient to provide helpful guidelines for limits and boundaries to limit the negative impacts of transference and countertransference (Jones, 2005). Mental health facilities can also support nurses by enhancing the development of resilience (Wampole, 2018), which includes offering adequate in-service training to help them strengthen various resilience attributes and develop coping mechanisms for difficult emotions (Ramalisa et al., 2018). The viewpoints explored in this chapter show that many nurses view providing care for women with psychosis as overwhelming, highlighting a potential source of stress that could be minimised by the recruitment of sufficient nurses and

the provision of adequate training (Salter & Rhodes, 2018). Facilities should also provide programs which target resilience-building behaviours among nurses to assist them with daily care challenges (Delgado, Upton, Ranse, Furness, & Foster, 2017), while nurses' self-care should also be encouraged as a coping mechanism for managing experiences of adversity in the care of women with psychosis. Encouraging and supporting nurses to take regular breaks, exercise, lead healthy lifestyles, and find an acceptable work-life balance may help develop resilience and allow them to address the challenges of offering care in a more positive light (Benadé, Du Plessis, & Koen, 2017).

From a research perspective, the nurses' recounting of everyday experiences of negative feelings and their willingness to discuss feelings such as sadness and pity suggest that these nurses generally approached this investigation with honesty and authenticity, making genuine attempts to discuss their feelings. They were open about their negative feelings in their sharing of encounters, feelings, and responses in their provision of care for women with psychosis, and they were also, in the main, aware of both what they feel and respond as they care for women with psychosis. Many of them could also articulate these emotions and experiences, although none of the nurses specifically defined these issues in terms of transference and countertransference.

Clearly, their experiences, as explored using van Manen's (2014) lived body and lived self-other existentials, are linked to the emotions they experience while relating to women with psychosis. Many mental health nurses reported negative feelings, particularly sadness, and some reported responding by crying for consumers when they felt nothing could be done to help them. This response arises from nurses not being educated or trained in empowering women to recover and helping them establish their self-help, self-control, and independence mechanisms (Schrack & Slade, 2007), which would be more positive responses than crying

due to feeling helpless to address the women's poor position. The main point is that nurses are likely to develop better ways to deal with transference and countertransference when they are encouraged to develop resilience and offered the tools and training to develop coping mechanisms to make them more capable of providing appropriate care for women with psychosis.

Educating nurses to effectively communicate and build relationships with women with psychosis based on trust and respect may also facilitate improvements in care that may help overcome nurses' own negative feelings. Mental health facilities would be well advised to consider enhancing the psychological support offered to nurses and both advocating for and promoting self-care among nurses to strengthen their abilities to cope with work stressors and provide better care to women with psychosis. Offering nurses support and helping them deal with transference and countertransference may help ensure that the inevitable emotional labour experienced when caring for women with psychosis is better managed.

9.4 Summary

This chapter has presented the second major theme arising from an analysis of nurses' perspectives, with a focus on the understandings of, and emotions experienced by, nurses in their provision of care for women with psychosis in KSA. This theme was identified using van Manen's (2014) lifeworld existentials, with the lived body being the main lens used to analyse nurses' overall perspectives related to their understandings of psychosis and their emotional experiences during the process of offering care to KSA women with psychosis. Other lifeworld experientials were also used to reveal specific factors affecting nurses' understanding and emotions. Rachel's perception of psychotic symptoms in women being related to the impact of technology was understood using van Manen's (2014) lived cyborg, and multiple nurses' experiences of relationships were explored with the lived self-other. The

nurses' experiences of stressful work situations and concerns such as shortages of staff were investigated using the lived thing, which was utilised alongside the lived time to reveal the consequences of under-staffing in terms of the limited time to care for women with psychosis (van Manen, 2014).

This chapter's central theme was divided into two themes: *understanding psychosis while providing care to women with psychosis* and *emotional labour experienced when caring for women with psychosis*. The first theme was then divided into three sub-themes: *Hospital A nurses' understandings of psychosis*, *Hospital B nurses' understandings of psychosis*, and *nurses' understandings of medication adherence and relapse in psychosis*. Hospital A nurses showed only limited understandings of psychosis, which might be linked to them having lower educational qualification levels than Hospital B nurses (see the *nurses' demographic details* Subsection in Chapter Six). Some nurses in Hospital A also revealed that they had no prior mental health training before beginning their careers, which might be another reason for their limited understanding of psychosis. A final reason for this limitation may also be inferred from some of their views that the in-service training and education available was limited, being either repetitive or inaccessible due to nursing staff shortages.

Academic institutions must be the first to address this limited understanding by offering additional mental health education and training for undergraduate student nurses. Hospital A might also need to consider its role in developing more motivating and accessible in-service training to enrich its nurses' understandings of psychosis as well as urgently addressing the shortage of nursing staff to relieve obstacles to attendance at in-service training. Hafsa highlighted the need to complete her education, and this need should be recognised by Hospital A managers, who may wish to encourage nurses to complete their postgraduate education and improve their understanding of the mental health field.

Hospital B nurses' perspectives highlighted that this group had some understanding of psychosis. Rachel suggested that the use of CCTVs in the women's rooms escalated some of their symptoms, a perspective that may reflect the need for this practice to be reviewed by mental health ward managers to determine potential alternatives to CCTV use. Rachel also indicated the need for more up to date education about mental health nursing among nurses to improve their understandings of psychosis. Nurses in the OPDs similarly identified that they had only a limited understanding of psychosis due to a lack of mental health nursing practice in these clinics. These views highlight a need to expand nurses' roles in the clinics to permit and encourage them to engage with the women in their sessions.

Nurses generally affirmed their understandings of relapse in psychosis in the third sub-theme, suggesting that relapse generally results from medication non-adherence. Many also emphasised the role of the family in relapse, based on familial misunderstandings about psychosis and the role of medication. This view caused several nurses to emphasise the need to support and enable nurses to take on educational roles in communicating with women's families about psychosis and medication to help prevent or limit relapse.

Emotional labour experienced when caring for women with psychosis was the second theme in this chapter, and this was also divided into two sub-themes: *nurses' emotional experiences related to staffing concerns* and *experiencing transference and countertransference while providing care*. In the first sub-theme, the nurses suggested emotional stress was widespread due to concerns such as a shortage of nurses and high rates of absenteeism and sick leave, which were seen to increase workloads and to trigger further negative cycles of absence. A related concern was raised regarding nurses' job descriptions and roles and the numerous occasions on which they were asked to work outside them. Several nurses highlighted the need for more nurses to be hired to address staff shortages and to curb the cycle of

absenteeism noted in this area, allowing the concerns of nurses that may otherwise cause them to be absent to be revealed and addressed in good time. The issue of assigning nurses to roles not related to nursing might be best addressed by educating the hospital's other staff on the importance of nurses' roles and by allowing nurses to remain focused on offering the best possible care to the women with psychosis.

Concerning the second sub-theme, many mental health nurses reported experiencing emotional labour due to what is interpreted as transference and countertransference when caring for women with psychosis. These experiences were generally viewed as unfavourable, notably when the feelings concerned included women's sadness, which some nurses responded to with their sadness, by crying, for example. Identifying ways for nurses to deal with such issues more constructively by encouraging them to develop greater resilience and apply healthy coping mechanisms is an important way to support care for women with psychosis. Educating nurses to effectively communicate and build relationships with women with psychosis based on trust and respect may also help reduce negative feelings. Mental health facilities might also seek to enhance the psychological support offered to nurses and advocate and promote self-care among nurses to strengthen their abilities to cope with work stressors in providing care to women with psychosis.

The final point regards the ongoing nature of the service-user recovery approach (Schrang & Slade, 2007) in both hospitals. Concern about this issue is predicated on observations that some nurses in hospitals experienced the provision of physical and custodial care only; only where sympathy with women was felt were some nurses driven to give more care. The descriptions of their experiences suggest that nurses might not empower women to self-help, develop self-control, or seek independence. Many nurses also revealed they were not engaged in giving education to women and their families. These experiences, which were stressed by

many nurses, may need to be carefully considered by managers at both hospitals, particularly the provision of more education and training to nurses. Supporting nurses to expand their roles to offer more holistic mental health nursing care, including education, should advance the recovery orientation in these hospitals, and permit the development of a user-based approach (Schrang & Slade, 2007).

In the next chapter, the final theme in the nurses' experiences of providing care to women with psychosis is discussed: nurses' perspectives on the relationships they experience. These relationships include those with women with psychosis, those with other staff, and those with consumers' families, all of which have significant impacts on the care provided to women with psychosis.

Chapter Ten: Nurses' Experiences of Care for KSA

Women with Psychosis: Lived Self-Other

10.1 Introduction

The development of an understanding of how nurses relate to others is crucial in determining how best to assist nurses in managing and meeting consumers' concerns and needs (Kaite et al., 2016). This chapter highlights the third overarching theme in nurses' experiences of providing care to women with psychosis in KSA, focusing on how nurses relate to others while providing care. Analysis of the nurses' perspectives in this chapter was guided mainly by van Manen's lifeworld existential lived self-other (van Manen, 2014). The lived self-other also facilitated analysis of the impact of relationships on nursing care. The lived body was another lifeworld existential used to explore some nurses' bodily experiences that represent their thoughts, feelings, and behaviours, these experiences are linked to how they relate to others (van Manen, 2014). The nurses' experiences were clustered into three themes, as depicted in Table 10.1: *Family* incorporates the sub-themes of educating families and their expectations of and interactions with nurses; *Relationships* includes sub-themes of nurses' experiences of relationships with colleagues and managers, their language differences when communicating with women with psychosis, and how the symptoms of psychosis affect their relationships with women; and *Stigma and discrimination* which includes the sub-themes of nurses' experiences of stigma and social stigma.

As noted in the literature review, van Dusseldorp et al. (2011) suggests that nursing care provision for psychosis includes many domains; two key domains are developing therapeutic relationships and working with and supporting consumers' families. In this chapter, the domain of working with and supporting families is reflected in the theme of *family*. The

development of therapeutic relationships is reflected in the sub-themes of language differences when communicating with women with psychosis and the impact of symptoms of psychosis on relationships. The reflection of the literature here highlights the importance of these two domains in KSA's nursing care for psychosis; by matching the views of nurses here to existing literature, new perspectives can be generated to extend previous research. Moreover, research is lacking on nurses' experiences of relationships while providing care to women with psychosis in KSA, and the exploration in this chapter may help address this research gap. Overall, the development of an understanding of what it is like for nurses to relate to others while providing care for women with psychosis and the strategies and interventions that help nurses provide care are highlighted in this chapter.

Table 10.1: Themes and sub-themes representing the overarching theme of nurses lived self-other experiences when caring for women with psychosis in KSA

	Theme 1: Family	Theme 2: Relationships	Theme 3: Stigma and Discrimination
Sub-theme 1	Educating families.	Experiencing relationships with colleagues.	Nurses' experiences of stigma.
Sub-theme 2	Families' expectations of and interactions with nurses.	Experiencing relationships with managers.	Social stigma.
Sub-theme 3		Effects of language differences when relating to women with psychosis.	
Sub-theme 4		The impact of symptoms of psychosis on how women relate to nurses.	

10.2 Theme 1: Family

The theme of *family* was identified through nurses' perspectives on experiencing relationships with family as part of their caring experiences for women with psychosis in KSA. Nurses working with and supporting families is a specific domain of nursing care interventions for psychosis, as identified in the literature review (van Dusseldorp et al., 2011). This domain offers a sense of nurses' experiences of caring for women with

psychosis, as nurses incorporate working with and supporting families as part of their caring for women. This domain is illuminated by some nurses' experiences, and in keeping within the interpretation frame of van Manen's (2014) lifeworld existential: lived self-other, the *family* theme encompasses two sub-themes: *educating families* and *families' expectations of and interactions with nurses*. These sub-themes are illustrated in the following sub-sections.

10.2.1 Sub-theme 1: Educating families

Educating the family is a subtheme of the *family* identified through nurses' views on how family psychoeducation is part of their experience of caring for women with psychosis. This sub-theme is related to the previous chapter. The examination of nurses' understandings of medication adherence and relapse suggests that they link these aspects to the families and their limited education, which are identified as factors that may help or hinder nurses' care for women with psychosis. Therefore, the sub-theme of *educating families* was identified to illustrate how nurses experience working with families through education to improve their understanding of psychosis. The nurses' experiences of engagement with the families of women based on the need to provide education as part of care were understood within the framework of van Manen's (2014) lifeworld existential: lived self-other.

When a family of a consumer with psychosis has limited awareness of the illness, despite the onset of symptoms, this can result in longer durations of untreated psychosis, which may have many negative consequences (Devi Thakoor et al., 2016). Therefore, educating consumers' families to increase their awareness of mental illness is an essential part of treatment for people with mental illness (Lima, Selau, Menegalli, Magalhães, & Rosa, 2017). The nurses' role in working with and educating families is essential; however, nurses may not perceive this as related to their care of consumers. Goudreau, Duhamel, and Ricard (2006) argue that most nurses see psychiatrists and social workers are giving family meetings and

education as nurses have no time to work with families on these responsibilities. This perspective suggests that the limited time of nurses is a hindering factor in providing education to families.

The following nurses' views illustrate that families often lack understanding of psychosis, while nurses perceive that working with families is a necessary part of their care for women with psychosis. In the previous chapter, Catherine from Hospital B expressed her understanding of relapse prevention through medication adherence (see Sub-section 9.2.3). She commented on the lack of communication with families after women are discharged, reflects the fact that no continuity of nursing care for women. She also recommended the need for continuity of nursing care for women through family communication and education after discharge. The same concern was reported by White et al. (2019), who found that nurses in inpatient wards usually do not communicate with consumers' families; however, they suggested that nurses believed this to be a missing part of nursing care (White et al., 2019), as in Catherine's case.

Majidah from Hospital A suggested that families lack knowledge about illness: '70% of families are supportive [of women with psychosis], but they lack the proper knowledge [about psychosis]' (p3, line 108). She recommended that 'both families and consumers must have the necessary knowledge [about psychosis] delivered by nursing staff' (p. 3, lines 117-118).

However, Rebecca from Hospital B stated that 'The education for the family [is] not sufficient here [in the hospital], this is what I felt' (p1, lines 23-24). She also recommended educating the families: 'The family needs a specialised nurse to educate them about the [consumer]. I suggest the nurse [rather] than other specialists, [as] she knows the [consumer], and she knows how to take care of the [consumer]' (p. 3, lines 87-89).

Overall, through the lived self-other existential (van Manen, 2014), the nurses expressed their views of providing care to women with psychosis by relating to their families through providing education. Many nurse participants explained that a consumer's family generally requires a nurse to educate them about mental illness. The nurses in Moe, Kvig, Brinchmann B, and Brinchmann BS (2012) discussed using family contact networking to ascertain how consumers with psychosis managed daily activities, symptoms, and medication adherence: this practice emphasises the importance of nurses relating to families as part of facilitating consumers' care. Moreover, engagement with and education of families have been affirmed as elements of the user-based recovery approach (Schrang & Slade, 2007). However, for nurses to be competent to develop family education, they require access to the necessary knowledge and skills to build their confidence to perform this role (Fung & Fry, 1999).

This sub-theme revealed nurses' limited provision of education to the family of women. In the next sub-theme, nurses expressed views about how the family's expectations and interactions affect their care of women with psychosis.

10.2.2 Sub-theme 2: Families' expectations of and interactions with nurses

Nurses' views about families' expectations and reactions were investigated through van Manen's (2014) lifeworld existential: lived self-other. The interactions of families with mental health professionals were reported by Kaas, Lee, and Peitzman (2003). They found that mental health professionals have complex reactions and communications with families of consumers with mental illness. These reactions represented families having difficulty communicating with consumers or denying the seriousness of the problem; the reason for this was the family lack of knowledge and understanding about illness or treatment (Kaas et al., 2003). These forms of family reactions and communications were stressed in the present research by the nurses. Rachael from Hospital B discussed the expectations and interactions

of families regarding treatment and how these impacted the nurses' care for women with psychosis. She said:

Another thing disabling [our care], I feel, is [the] high [family] expectations. They expect 100% recovery, [but] psychosis is not going like that, [it is a] long process and a long time of medications, and it takes a long time, so they [disagree] with that. When they [are not] happy when we tell [them this, it] ...makes pressure on us, when they cannot...see the improvement [, and when] they [do] not agree with us. (p. 4, lines 149-153)

Rachael's view is that high and unrealistic expectations of families lead them to disagree with nurses about their relative's progress, creating stress for the nurses providing care. More stress might come from the women with psychosis, as they experience the disappointment of their families regarding their treatment and progress. The reason for the family's unrealistic expectation might reflect they were not informed or educated about psychosis and recovery. These expectations might affect nurses by causing them to provide additional care to make them more satisfied with the treatment and care provided.

The nurses illustrated their views with family interactions relating to the effect on their experiences of care. Saleha, a nurse from Hospital A, described many family interactions, such as when a family shows a lack of interest in their loved one's treatment:

As for the consumer's family, sometimes they represent a barrier for us. Most families are not interested in the treatment regimen or lack the appropriate knowledge of handling a consumer. Most of them need to gain knowledge about mental illnesses. Meanwhile, some families are aware of the treatment, and they tell us they should be informed of any developments or issues that could appear...regarding their consumers. (p. 2, lines 81-85)

Saleha's opinion highlights how interactions with a family as part of mental health care are made more difficult by their lack of knowledge and understanding about the illness or treatment. This point was emphasised by Kaas et al. (2003), who referred to a family's lack of knowledge or denial of the seriousness of the illness, as the main reasons family

interactions with mental health professionals are complicated, and a barrier to care, as Saleha believed.

Ahd identified specific family interactions which create barriers to nursing care, and stressed difficulties when gaining family approval for medication which could improve a woman's condition. This medication, according to the researcher's experience, is the antipsychotic Clozapine. Clozapine in that hospital is offered as a last alternative for antipsychotic medications due to its adverse effects on the immune system; therefore, it needs family approval. Ahd said:

Sometimes families tire us for some issues, [such as] when we try to get their approval for specific medication that could improve the consumer's case [but] has many side effects. The consumer [then often keep] suffering from the current medication [because her family does not approve a change to her medication]. (p. 3, lines 101-103)

Ahd's view is that failure to approve a change in medication is a factor impacting the care.

As the women will not improve, this increases the burden on the nurses, as Ahd illustrated.

Ahd's view reflects the general opinion among nurses that families do not have enough knowledge and understanding of the various relevant medications and illnesses (Kaas et al., 2003). The lack of understanding of medications might explain the interactions and encounters with not approving new medication from Ahd's perspective.

Sophia, from Hospital B, reported that family interactions may interfere with nursing care:

Sometimes we experience the families during visiting time interfering with our care; we ask our doctors to explain to the family, but they [families] sometimes do not agree with the patient's care ... [because] the [consumers]...tell their complaints to the family [about nurses' care], which we encounter especially with those [consumers] who are suspicious of nurses. (p. 2, lines 62-66)

Sophia's point underlines the notion that family interaction can cause interference with nursing care. Sophia refers to interference in women who mistrust the nurses and make complaints to their families, which triggers family disagreement with nursing care. This view

reveals the barriers hindering nurses' development of relationships with consumers' families based on the conflict between consumers and nurses (Winefield & Burnett, 1996), where mistrust is prominent between both parties in Sophia's view.

The nurses' views of *families' expectations of and interactions with nurses* are touching on how nurses relate to families, which affects their caring for women with psychosis. Nurses explained how their relationships with families were affected by their expectations and interactions and discussed how this affected the care process; these perspectives were revealed within the framework of lived self-other (van Manen, 2014). Nurses illustrated many aspects of the ways families relate to nursing care, including their high and unrealistic expectations about care and treatment, their lack of interest in treatment and care, their withholding of approval for alternative medication, and their interference with nursing care. These views suggest that it is anticipated that nurses can work to manage these aspects of their relationships with families to improve the care offered to women with psychosis. The first way to manage the expectations of and interactions with families is to increase family understandings of psychosis through education; this issue is linked with many nurses' views from the previous sub-theme of *educating families*. As soon as a therapeutic relationship with the family has been established, it is vital to educate the family regarding psychosis and its symptomatology, emphasising the importance of adherence to treatment (Pinho et al., 2017). Such education and the resulting increased understanding might allow family expectations about recovery from psychosis to become more realistic. It also makes families more interested in supporting adherence with treatment and accepting alternative medication where the critical issue is that the predicted treatment outcomes outweigh the potential side effects. An improved understanding of psychosis might also reduce disagreement and conflict between nurses and families, as families may broaden their thinking about both treatment and illness.

The theme of *family* is represented in the nurses' experiences and their relationships with consumers' families are linked to their care of women with psychosis. However, many other experiences of relationships are linked to different aspects of nursing care outside the family, which are discussed in the next theme, *relationships*.

10.3 Theme 2: Relationships

This theme was identified by analysing nurses' views on their relationship experiences linked to providing care to women with psychosis. The nurses' perspectives were explored through van Manen's (2014) lived self-other existential. Four sub-themes were identified:

Experiencing relationships with colleagues, experiencing relationships with managers, effects of language differences when relating to women with psychosis, and the impact of symptoms of psychosis on how women relate to nurses (see Table 10.2). Many participants offered experiences illustrating these sub-themes.

The first two sub-themes *experiencing relationships with colleagues* and *experiencing relationships with managers*, are introduced, and discussed in detail in the relevant sub-sections. The remaining two sub-themes, *effects of language differences when relating to women with psychosis*, and *the impact of symptoms of psychosis on how women relate to nurses* can be linked closely to existing literature, as these sub-themes relate directly to the nurses' therapeutic relationships with women. Nurses' engagement in and development of therapeutic relationships with consumers has been identified as a key domain of nursing practice for psychosis (van Dusseldorp et al., 2011), reflecting that their relationships with consumers affect nurses' experience of providing care. Therefore, the nurses' experiences regarding language issues when communicating with women and how nurses manage symptoms of psychosis affect their caregiving. This perspective represents the impact of therapeutic relationships as the domain of practice on nurses' care provision.

Table 10.2: Theme of relationships and its sub-themes representing nurses' experiences of providing care to women with psychosis

Theme of Relationships	
Sub-theme 1	Experiencing relationships with colleagues.
Sub-theme 2	Experiencing relationships with managers.
Sub-theme 3	Effects of language difference when relating to women with psychosis.
Sub-theme 4	The impact of symptoms of psychosis on how women relate to nurses.

10.3.1 Sub-theme 1: Experiencing relationships with colleagues

The nurses viewed their relationships with colleagues, whether other nurses or those from other disciplines, as a fundamental aspect of nursing care in a multidisciplinary team. The sub-theme *experiencing relationships with colleagues* was identified in the theme of *relationships*. Nurses' experiences of relationships with colleagues were understood within van Manen's (2014) lived self-other existential.

As illustrated by the nurses' views, colleague groups include nurses and a range of other mental health care professionals: psychiatrists, psychologists, and social workers. Support of colleagues has been shown to provide a basis for nurses to build effective relationships and increase their confidence in providing care (Mozaffari, Peyrovi, & Nayeri, 2015). Mozaffari et al. (2015) reported that nurses frequently experience frustrations, such as dealing with managers or consumers, where they need support from their colleagues to make good decisions related to the care provided to consumers. Relationships with colleagues are also essential for several other reasons, including coordinating care across shifts or sites, promoting the quality and safety of care, and establishing and maintaining standards of professionalism to improve the care provided to consumers (Padgett, 2013).

Some participants reported relationship issues with other nurses and team members such as psychiatrists and psychologists, and these participants identified these relationship issues as affecting the care they provided to consumers. For example, Anna from Hospital B discussed

her experience of problematic relationships with some other nurses, and expressed her displeasure with what she perceived as other nurses' interference in her care for women with psychosis: 'If I want to deal with the [consumer], I do not want someone to interfere ... if she is my [consumer] I do not want [you] to interfere; otherwise if you [nurse] touch my [consumer], this is [a] problem' (p. 3, lines 66-68).

While Anna did not discuss what she meant by interference in-depth, this might relate to unnecessary or unorganised interventions by other nurses in the care provided to her assigned women. Padgett (2013) suggests that when a nurse performs a specific practice on another nurse's consumer, this may be seen as a challenge, potentially threatening group order. The underlying reason for such negative perceptions is the absence of a structure for and clear work culture of professional collegiality, which leaves little room for discussing practice challenges as anything other than interference (Padgett, 2013). Such actions are interpreted as personal attacks rather than being friendly or helpful teamwork, and they are not perceived as a way to improve care for consumers (Padgett, 2013). The perceived undermining of care to consumers may be linked to reduced job satisfaction, lowered motivation and decreased job performance and productivity, and these relationships may also have the potential for conflict in the workplace (Duddle & Boughton, 2007).

The need for colleagues to develop an appreciation of nursing care was stressed by Rebecca from Hospital B, who stated: 'This is a barrier [for care], [a lack of] appreciation from others. From [the] psychiatrists and psychologists, very rarely [do] we receive appreciation; we are not so much involved with them' (p. 2, lines 64-66). Rebecca noted that she felt that psychiatrist and psychologist colleagues did not appreciate nurses' care for women with psychosis. This lack of appreciation may drive the deterioration of collegiate relationships, undermining nurses' motivation to provide care, which is a factor in increased turnover

(Duddle & Boughton, 2007). Turnover could result from a lack of motivation, as indicated by Sabah's following excerpt.

Sabah, from Hospital A, asserted the lack of collaborative working with social workers and psychologists affected the provision of care for women with psychosis by increasing nurses' workloads:

Nothing is motivating me to continue working here. The social workers and psychologists do not attend [the ward] except for meeting with the crew [mental health team meetings with consumers], which means the whole responsibility falls on the nurses. [When] we need them and search for them in the departments, as the psychologists must arrange sessions for the mental health consumers, ... calls [have] the possibility of being answered by her [psychologist] or not. In the addiction ward [nurse's previous workplace], some of the sessions are organised by the psychologists, and in case of [the psychologist] being absent, we report her absence... to the administration. However, we complain about them a lot in this mental health ward. (p. 2, lines 71-78)

Sabah reflected that the nurses were not on good terms with the psychologists and social workers. This view highlights that teamwork in this setting lacks collaboration, which might affect the care provided to consumers; in particular, Sabah indicated a lack of motivation accompanying the increased workload. Teamwork in healthcare can be defined as an interprofessional collaborative practice by the team, based on collaboration between professionals from different areas to promote patient-centred care (Orchard, 2010); it offers a way to organise practices to take a broader approach to the health needs of consumers (Peduzzi, Norman, Germani, Silva, & Souza, 2013). Nurses' interprofessional collaborations are directed by many critical interactive dimensions such as communication, trust, professional bonds, and healthcare coordination, and these dimensions also help nurses provide care to consumers (Souza, Peduzzi, Silva, & Carvalho, 2016). In Sabah's view, nurses' collaboration with psychologists and social workers lacks many of these important dimensions of communication, as there is no reliable way for nurses to contact their colleagues when needed. The professional bond is weakened, and coordination between these

professionals is not strong, causing Sabah to feel a lack of motivation in her work due to the high demands of care placed on nurses.

These nurses' perspectives on their relationships with colleagues reflect how conflict and lack of appreciation and collaboration between nurses and colleagues may impact the care offered. Nurses' experiences with their colleagues were revealed by the lived self-other existential (van Manen, 2014). It is, therefore, necessary to find out how nurses can better manage these relationship conflicts in the workplace. Blake (1964) identified five styles of managing interpersonal conflicts in the workplace: forcing, withdrawing, smoothing, sharing, and problem-solving. Kilmann and Thomas (1977) refined this to five ways of managing conflict: competing, avoiding, accommodating, compromising, and collaborating. If some of these strategies, such as sharing and problem solving, were used by nurses like Anna, who experienced conflict and interference from colleagues, they might improve the satisfaction derived from caring for and working with women with psychosis. Where clinical supervision exists, clinical supervisors could also use these management styles to guide nurses in dealing more effectively with conflicts in the workplace, improving care. The researcher observed while collecting data in both facilities, that there was no clinical supervision for nurses. Therefore, it might be worthwhile for these facilities to create a clinical supervision system for nurses, to help nurses manage many aspects of their care, including collegial challenges and conflicts. It might also enable nurses to gain the attention of facilities to establish a system for teamwork collaboration, setting the terms and rules to facilitate the provision of care.

In addition to nurses' experiences of relationships with their colleagues, nurses' relationships with managers were perceived as crucial. This is the subject of the next sub-theme.

10.3.2 Sub-theme 2: Experiencing relationships with managers

The nurses viewed their relationships with managers as an essential part of caring for women with psychosis. Nurses' experiences relating to their managers were investigated using van Manen's (2014) lifeworld existential: lived self-other.

From these nurses' perspectives, their managers include the nurse managers and executive administrators. Nurmeksela, Mikkonen, Kinnunen, and Kvist (2021) note that enhanced relationships between nurses and nurse managers improve consumer outcomes and satisfaction with the care provided. The emphasis of this relationship can be viewed as improving nursing care by managing and organising nurses' work in ways that allow nurses to feel supported, motivated, engaged and secure (Nurmeksela et al., 2021). This supportive relationship between nurse managers and nurses influences job satisfaction (McCay, Lyles, & Larkey, 2018). By relating effectively with nurses, nurse managers can promote a healthy work environment with low levels of conflict (Shirey, 2017), which might relieve nurses' other conflicts in the workplace, such as those raised by Anna in the previous sub-theme, and enhance cohesiveness to provide better care.

Two nurses stated that their relationships with managers showed a lack of appreciation for providing care to women with psychosis. The participants highlighted that there was even insufficient acknowledgement of their efforts to provide care by management. Rebecca from Hospital B said that nurses do 'Not always receive appreciation from upper managers in the nursing department; where there is appreciation, one person just takes it' (p. 2, lines 66-67). Samantha also thought that the lack of appreciation from higher managers made it hard for nurses to develop their identities as professionals:

When we do more [work], we do not...benefit from [hospital managers].
You know, you are dealing with mental health [consumers]; you know, you
get beating from the [consumers], you get spitting...the relatives will annoy

you; we are in the front [line]...the problems come first to us. After finishing [that work], it [appreciation] will go to the doctor, so we need the support. We do not have that support from the higher [managers]...so we do not feel okay in ... our identity as mental health nurses. (p. 3, lines 115-121)

Rebecca and Samantha, both from Hospital B, believed they were not appreciated or rewarded as employees. Social wellbeing, in Samantha's view, which would allow the development of nurses' professional identities, was described as limited because of insufficient appreciation by and support from managers. Another study has shown that organisational support and fairness in rewarding employees develop satisfaction and wellbeing among professionals (Mozaffari et al., 2015). Framing these views within van Manen's (2014) lifeworld existential: lived self-other, managers may undermine nurses' wellbeing by not giving nurses enough appreciation for their care provision. This social wellbeing could include professional identity, as in Samantha's excerpt, and when undermined, this may have consequences including lowering nurses' motivation to provide care for women with psychosis. Facility managers could enhance and organise an appreciation and reward system for nurses, which could motivate nurses to provide better care.

Nurses' experiences of relationships with colleagues and managers are linked to their care for women with psychosis. Nurses in Hospital B also illustrated that not being an Arabic speaker and trying to communicate with Arabic women with psychosis caused relationship issues. This experience was linked strongly to the care provided by expatriates, whose views are explored in the next sub-theme.

10.3.3 Sub-theme 3: Effects of language differences when relating to women with psychosis

All participants from Hospital B were expatriates (see Chapter Six: Nurses' demographic details) who spoke English fluently; however, their Arabic was not fluent or was even totally lacking, while many consumers and their families spoke only Arabic. The participants from this hospital perceived language differences to be an important aspect affecting the care provided to women. The nurses' perspectives on language difficulties when communicating with women were explored with van Manen's (2014) lifeworld existential: lived self-other.

According to Francis, O'Connor, Chapman, and Allen (2007), language provides humans in various situations with a rich tapestry of ways to communicate meaning and understanding within a community. Through language, communication is conveyed. The Macquarie dictionary defines communication as 'the imparting or interchange of thoughts, opinions, or information by speech, writing or signs' ("Communication," 2020, p. 170), and Francis et al. (2007) suggested that communication is an essential component of professional nursing, with relevance to the currency of care for each consumer. Francis et al. (2007) added that language is used to facilitate the provision of high-quality care and inform and educate recipients about that care, which is essential to what is transmitted and interpreted by both nurses and consumers. Nurses acknowledge that language facilitates understanding and meaning and reinforces expectations that those caring for consumers know what they are doing (Francis et al., 2007). In general, nurses who have competence in the languages of their consumers are seen as better able to contribute to building positive relationships with both consumers and colleagues to improve health care (El-Amouri & O'Neill, 2011).

Language differences were perceived by nurses in this research as a barrier to care, especially when interacting with consumers on issues such as symptoms. Graham, Bradshaw, and Trew

(2009) highlighted how language barriers affect health professionals in general, and indicated that this barrier is exacerbated for mental health professionals; this occurs because health care plans in this area rely primarily on communication skills, which in turn require a complete understanding of the consumers' language. Betancourt, Green, and Carrillo (2002) showed that culturally competent nursing care may be hindered when nurses have different linguistic backgrounds to their consumers.

Rebecca described her experience with language differences when providing care in negative terms:

...language is very [essential] here. [Where] the [consumer] tells us about the symptoms, we cannot catch all the symptoms because of the language barrier; the [consumer] may have said one thing, and we perceive another thing because of the language barrier. (p. 1, lines 25-28)

For Rebecca, miscommunication between expatriate nurses and consumers occurred due to language differences. The confusion between mental health nurses and consumers caused by language misunderstandings has a long history in mental health nursing, according to Stacey, Felton, Bonham, and Holland (2012), who identified culture and language as pivotal in the assessment and care of consumers. There are language-based misunderstandings between nurses and consumers, and a significant decline of care is likely (Stacey et al., 2012), as noted by Rebecca. Graham et al. (2009) also reported that health professionals have suggested that consumers withhold information and do not explain their situation or what they need because of language differences. Consumers may also have difficulty dealing with even simple problems which arise when they cannot understand what they are required to do (Graham et al., 2009). Errors in care may also arise when effective communication is prevented by a lack of language (Jirwe, Gerrish, & Emami, 2010).

Sarah also mentioned difficulty in giving mental health support because of language problems:

Norah: Just I need to return to one point: you said that there is a language barrier, so does this barrier affect your care for these women? If yes, how?

Sarah: For care, it is not a barrier, but when it comes to mental support, it is...a barrier; words or vocabularies we do not know include [those that are] reassuring for the [consumers] if they feel sad, as an example. (p. 3, lines 89-93)

Sarah believed that language differences were mainly a barrier to giving emotional support to consumers; this supports the idea that an understanding of the language of the women concerned is necessary, but she also mentioned that this did not impact the care given to them more generally. However, she did not explain which care was not impacted, and Sitzman and Eichelberger (2015) reported that nurses should provide care in partnership with the consumer, rather than doing things to the consumer, which suggests that fluent communication is essential to forming a partnership which improves understanding and supports care. Therefore, in Sarah's care, while she is making the point that she can provide physical care with Arabic speaking consumers, but not mental care, language and communication are considered parts of nursing care, even if she could not perceive that as impacting her care of women with psychosis.

Madison argued that when nurses cannot understand Arabic, they struggle to give the best care in her hospital:

The first [barrier of care] I [would] say [is] the language. Sometimes we cannot understand the language and sometimes... [women with psychosis] [speak complicated] Arabic so I cannot understand, so I cannot give my care ... in that case, you must ask somebody or write some notes because sometimes I cannot remember what she [woman with psychosis] said. Then I ask the doctor about what she said. That is how we deal with the [consumers]. So, the first barrier is communication, and this [language difference] is the barrier. (p. 2, lines 80-84)

Madison suggested that nurses cannot understand Arabic when consumers speak Arabic dialects or have accents that are very hard to understand for non-native speakers; in these cases, nurses have difficulty giving care and must ask somebody to interpret or write notes. A potential risk to consumers' wellbeing arises when health professionals cannot connect or

relate to consumers and understand their issues and immediate problems due to language barriers (Graham et al., 2009). This risk to care causes Madison to consider language the first barrier to her care.

These nurses' views are understandable based on their experiences of difficulty in giving care to women with psychosis due to language differences. The nurses' experiences of lacking the ability to communicate fluently in Arabic with the women were understood with the lived self-other (van Manen, 2014). This impact suggests that nurses must understand their consumers' language, which poses a challenge for non-Arabic speaking nurses, who need to overcome language barriers to ensure high-quality care is provided to their consumers and maintain consumer satisfaction (Badrudin & Arif, 2017). This language misunderstanding of nurses in Hospital B was amplified with the absence of professional interpreters.

Moreover, although nurses recognise this inherent dilemma, they struggle to overcome linguistic differences in their work context to provide culturally competent care (El-Amouri & O'Neill, 2011).

One nurse, Caroline, suggested a strategy for managing this difficulty, the provision of courses in Arabic for non-Arabic speakers: 'I said [previously] that [one] barrier that we [have] is not speaking well in Arabic, so ... of course you need to study Arabic for non-Arabic speakers' (p. 2, lines 70-71). Madison also discussed self-learning strategies to understand and speak Arabic to provide better care for consumers:

Because the [consumers] are Arabic, we need Arabic skills, [especially] if we are newly [arrived in] Saudi [Arabia]; we need to learn Arabic. That is very important, so the [consumer] understands you, especially in [mental health], which [is] focused more on communication. [It] is [essential for consumers] to understand us, so for me, if I [am] very, very new, I should study Arabic, especially in my first year. That is what I say to any new staff; they should be obliged to learn Arabic. I found this easy; this was my way nobody forced me. [I] learned the basics...the complaints...parts of the body...[and] numbers during [the first] two years. I did not work in [mental health] ...and I was alone in the emergency; nobody helped me. If

a person does not learn Arabic, they will not approach [the consumer] ...you [can go and] ask [an Arabic speaker]: how I can pronounce this [word], then ... write that in the note, that is what I did, I had my notes. So, my experience [of care is] based [on] understanding the [consumers] and communicating well. (p. 1, lines 35-45).

Caroline and Madison suggest strategies of learning Arabic to facilitate communication with consumers. Their views represent an appreciation of the essence of learning another language as a way of appreciating culture: as O'Neill (2008) noted,

Learning more than one language demands and facilitates the necessary appreciation of the culture/s involved. It requires people...to 'get inside the skin' or 'stand in the shoes' of their cross-cultural counterpart[s]. Acquiring another language is...beneficial because it allows one to appreciate the world through the 'eyes' of another culture. (p. 14)

In addition to applying Arabic learning strategies, mental health facilities can help nurses overcome language difficulties by offering other support. When asked to suggest strategies to facilitate cross-cultural communication and develop linguistic resources, the participants in El-Amouri and O'Neill's (2011) study identified a need for written translations of material and multimedia resources and support aids; also the provision of translators and interpreters to support communication. The researcher of the present study did not see any translated materials or interpreters on the wards. Provision of these supports might be recommendations for these mental health facilities to address. As a mental health nurse, the researcher knows that communication is vital in mental health nursing; after interviewing the nurses, she wondered, why nurses who cannot speak Arabic are recruited and employed if other strategies such as interpreters and translated materials are not in place. Such strategies might help improve the mental health care provided to women with psychosis by helping overcome language differences.

Alongside the impact of language differences on nurses' relationships and on the provision of care to women with psychosis, symptoms of psychosis also impacted how nurses relate to

women, and this was identified as the final sub-theme within the theme *relationships*. This sub-theme is explored in the following subsection.

10.3.4 Subtheme 4: The impact of symptoms of psychosis on how nurses relate to women

The nurses' views about the impact of psychotic symptoms on their relationships and caring for women with psychosis were analysed using the lived self-other existential identified by van Manen (2014). Psychosis is a severe mental illness with specific symptoms, which may create obstacles to therapeutic relationships (Pinho et al., 2017). As noted in the literature review, according to Moe et al. (2012), nurses commonly experience difficulties engaging in relationships with consumers experiencing psychosis and have issues supporting their care. One major obstacle is that consumers may have difficulty expressing requests for help, even when a caring relationship exists (Favrod & Maire, 2014). In the present study, many participants noted that symptoms of psychosis affected their relationships with consumers which in turn influenced their care.

Saleha from Hospital A illustrated how dealing with psychotic symptoms could form a barrier for nursing care:

The barriers [to providing care to women with psychosis include] ...that it is hard to deal with a psychotic consumer. [Such a] woman does not know that I want to help her, so she isolates herself. Thus, most barriers appear when I try to convince her to take her medication because she usually refuses to take it. She could think that there is something wrong with the treatment, so I cannot provide the appropriate care because of the woman herself. We waste much time trying to convince [a woman] that she should have a shower or change her dress. (p. 2, lines 66-71)

Concerning psychotic symptoms, Favrod and Maire (2014) indicated that therapeutic relationship difficulties might be presented by consumers who do not see a need for help and block nurses' attempts to establish contact. This perspective was confirmed by Saleha's

experience of women blocking nurses' attempts to form relationships and therefore not allowing the provision of care.

Samantha believed that women with psychosis do not trust nurses, explaining her response to and care for them. She also linked the challenges in relating to women experiencing these symptoms with language differences, as seen in the previous subtheme:

Norah: You mentioned that the consumers are suspicious and did not trust nurses, referring to suspiciousness related to the illness. Please talk about it.

Samantha: Yes, some [consumers] do not like some nurses, they do not trust the nurses, [which] is part of their disorder.

Norah: What about your responses...toward women with psychosis, as if you find women who are suspicious or hearing voices?

Samantha: We just say it is okay, because, you know, we have language problems also: they [speak] Arabic, we talk English, so if they say something...[we] just say okay, no problem, [and] leave them...because it is not good to argue ... because of their condition. (p. 2, lines 52-61)

She believed that consumers with psychosis were suspicious due to their illness which caused them not to trust nurses. This mistrust hinders communication and the establishment of therapeutic relationships. However, Curtis and Fegley (2016) reported that it was difficult to establish trust with consumers experiencing psychosis, especially when they suffer from paranoia, and all nursing interventions are seen as suspect. Consumers may be desperately lonely yet defend themselves against all expressions of kindness, compassion, and trust (Curtis & Fegley, 2016). Samantha's observation of mistrust between nurses and consumers could make nursing care more challenging and exhausting for nurses. Samantha also linked difficulty in relating to these women to language or cultural barriers, as explored in the previous sub-theme. This barrier, together with symptoms of psychosis, might exacerbate the burden for nurses providing care, by making consumers even more reluctant to accept relationships with them.

The nurses' statements reinforce the difficulty of developing relationships with women with psychosis and the impacts on nurses' care experiences. Nurses' experiences of relationships with women experiencing psychotic experiences were investigated using the lived self-other (van Manen, 2014); these nursing experiences can be managed to provide better care.

However, in the study of Engqvist et al. (2010), nurses discussed the importance of using *presence* interventions to offer care to women with psychosis, sitting with the consumers, listening to their stories, and doing everyday tasks with them to allow consumers to develop a sense of being well cared for. This technique also increases a nurse's capacity for empathy and facilitates consumer comfort and trust by creating meaningful connections (Engqvist et al., 2010). Engqvist, Nilsson A, Nilsson K, and Sjöström (2007) also examined mental health nursing care for women with PPP and identified strategies for care which could be applied in therapeutic nursing interventions, including presence and continuity of care, satisfying consumers' basic needs, and encouraging feelings of security. If used by nurses such as Samantha, these strategies might reinforce consumers' sense of trust and security, creating better relationships. However, nurses like Samantha may need to be supported by mental health facilities to manage language differences before applying these strategies to women who speak other languages.

Within the theme of *relationships*, nurses' experiences of caring for women with psychosis were explored with the lived self-other (van Manen, 2014). Their experiences of relationships with their colleagues and managers were highlighted, along with expatriate nurses' experiences of language difficulties in relating to and communicating with women. Finally, some nurses had difficulties in relationships with women with psychosis because the symptoms can affect acceptance of the care provided.

The next theme examines nurses' views on stigma and discrimination and how they affect the care provided to women with psychosis.

10.4 Theme 3: Stigma and discrimination

This theme is divided into two sub-themes: *Nurses' experiences of stigma* and *social stigma*.

The stigma and discrimination reflected in nurses' views were explored using van Manen's (2014) lifeworld existential lived self-other. Some nurses also expressed stereotypes and perceptions indicating the stigma; the lived body existential (van Manen, 2014) was used to understand these perspectives.

Stigma is defined by the WHO (2001) as a 'mark of shame, disgrace, or disapproval' (p. 16) often applied to those living with mental illness. Discrimination may result from the stigmatisation of mental illness, causing sufferers' human rights and freedoms to be violated in all facets of life, including access to mental health care (WHO, 2012). Discrimination can be viewed as unfair treatment due to an individual's identity, including their mental illness (Canadian Mental Health Association, 2020). Despite strict rules in health systems against stigma and discrimination against consumers with mental illness by healthcare professionals, consumers still experience widespread stigma and discrimination (Tyerman, Patovirta, & Celestini, 2021). The literature suggests that healthcare professionals, including nurses, may exhibit stigma towards individuals coping with mental illnesses almost as frequently as the general public (Hauck et al., 2015).

This theme explores how stigma and discrimination in response to mental illness shape nurses' perceptions and, ultimately, affect their care of women with psychosis. The nurses' views illustrate the first sub-theme of nurses' stigma which may affect the provision of care

to women with psychosis, and the second sub-theme of social stigma and its impact on nursing care for women is also highlighted.

10.4.1 Sub-theme 1: Nurses' experiences of stigma

The first sub-theme to emerge from the *stigma and discrimination* theme was nurses' own experience of stigma. The nurses' views highlighted their experience of stigma when caring for KSA women with psychosis or symptoms of psychosis and reflected a crucial element of the nursing care experience. Nurses' experiences that highlighted stigma were analysed using the lived self-other and lived body lifeworld existentials (van Manen, 2014), meaning that experiencing stigma was linked into nurses' experiences, which encompassed their thoughts, feelings, and behaviours. These experiences were also linked to how the experience of stigma affected their relationships with women.

Nurses might display stigma and discrimination against consumers living with mental illness (Bates & Stickley, 2013), and this behaviour by nurses might negatively impact the quality of person-centred care and nurse-consumer relationships due to nurses' inability to build rapport with consumers (Tyerman et al., 2021). The factors contributing to nurses' stigmatisation of mental illness include nurses' inability to relate to consumers with mental illness due to lack of knowledge and skills, media portrayals of mental illness as dangerous and fearsome, and the historical biomedical model of mental illness which has consistently ignored social and psychological understandings of mental well-being (Bates & Stickley, 2013).

In this study, the nurses offered several views representing the emergence of stigma while providing care to women with psychosis. The nurses did not use the term *stigma*: however, the researcher interpreted this based on exploring nurses' reports of their experiences while providing care to women. Stigma was expressed as feelings of annoyance, as in Rabab from Hospital A, who said about her response when she heard a woman hallucinating and

screaming during the interview, she said, ‘This consumer who is screaming, who will tolerate her?’ (p. 5, line 175).

Madeeha from Hospital A discussed her attitudes, feelings, and responses when providing care to women in ways that may reflect certain stigma types:

I deal with the consumer day by day, as if she does not [do] anything wrong. I show that I am angry with her, but I do not remind her of her fault the next day, as she is like a child. However, if I can specialise in a specific diagnosis, I prefer dealing with consumers with dementia than with psychosis. (p. 2, lines 49-53)

Rabab’s expression of annoyance can be added to the variety of feelings and responses she expressed in the previous chapter related to countertransference (see Chapter Nine, sub-section 9.3.2), which were disgust, fear, anger, and avoidance. These feelings and responses indicate some stigma being attributed by this nurse. Madeeha also expressed feelings and responses when providing care to a woman with psychosis. She highlighted both her readiness to provide better care to women, including not reminding a woman about previous issues, and some more negative issues, such as being angry at a woman’s behaviour, believing that she is like a child, and preferring not to deal with consumers with psychosis. These feelings and responses might reflect various forms of stigma.

Nurses presented stigma in many forms, such as viewing consumers as undesirable, as with Rabab’s lack of tolerance for the woman with hallucinations and Madeeha’s preference for not providing care to women with psychosis. Such attitudes may arise due to the large number of resources required to provide care for such consumers (Kaufman, McDonell, Cristofalo, & Ries, 2012). This perspective appears to apply to Madeeha, who discussed how she needed to care for a woman with psychosis using various skills, which might have caused her to express the undesirability of having to provide such complex care all the time. The undesirability of providing care is not appropriate for mental health nursing care, and this

stigma may highlight the lack of focused mental health education and training (Vandyk, 2015) and the understanding of psychosis which Madeeha revealed. This lack of knowledge was also reported by Poggenpoel, Myburgh, and Morare (2011), who noted that the lack of knowledge and skills in mental health nursing led to discomfort and anxiety arising from the attribution of stigma when caring for people with mental illnesses. The other interpretation of that feeling is that there may be a community sense of understanding of psychosis based on stigma which influenced Madeeha's view of providing care to women with psychosis. However, the consequences of this overall feeling of discomfort when providing care to consumers with mental illness, as seen in the cases of Madeeha and Rabab, include annoyance, anger, and a lack of desire to provide care, making it difficult for nurses to build effective relationships with consumers (Zolnieriek & Clingerman, 2012).

Manahel from Hospital A also perceived consumers requiring acute care as childlike in their helplessness: 'When the consumer is [acutely] ill, she is like a child, so I give her priority' (p. 1, line 32). Manahel and Madeeha's views about caring for women with psychosis like children highlight a particular form of infantilising stigma. Gaillard, Shattell, and Thomas (2009) reported that a diagnosis of mental illness often leads mental health professionals to assume that consumers cannot function well, leaving consumers feeling as if they are no longer in control and removing their autonomy or self-determination. While nurses who view women as children have pure intentions, seeking to give them more care because of this perspective may negatively affect women's autonomy and empowerment due to the resulting stigma. This adverse effect of disempowering women might affirm the service-used recovery approach nurses use in their care for women (Schrunk & Slade, 2007).

Malak, from Hospital A, suggested that women looked like *zombies* after they moved into the new building:

Once I entered their [women with psychosis] rooms, [I] felt as if they were like zombies. I used to enjoy the time I spent with them, but now everything has changed. Their psychological state badly affects them since they moved to the new building. (p. 2, lines 88-91)

In Hospital B, Sophia's experience with stigma is represented in the labelling of the women with illness. Sophia noted, 'Most of them [women with psychosis] are in their...world especially *schiz* [sic]' (p. 1, line 34). Malak's view of why the women's appearances changed was related to the change of space in Hospital A's new building. Malak labelled the women's appearance as *zombie*-like, which may be linked to her experience of stigma. Sophia's labelling women with schizophrenia as *schiz* is a similar sign of stigma. While Sophia may simply claim this is shorthand for schizophrenia, referring to someone as schizophrenic is not preferred in the mental health field, and labelling someone as *schiz* is unprofessional.

The nurses' perspectives revealed stigma as they labelled consumers with the illness or its symptoms (Ewart, Bocking, Happell, Platania-Phung, & Stanton, 2016). Sophia's reference to a woman with schizophrenia as *schiz*, reflected labelling with the illness. In addition, Malak's description of women as *zombies* might be regarded as labelling women with a symptom of psychosis. Negative symptoms may be secondary to conditions related to psychotic experience, and Malak gave one situation, which was the change of the inpatient space. According to Kirschner et al. (2017), the institutionalisation of consumers may be a reason for negative symptoms. The side effects of antipsychotic medications and over-sedation might also contribute to negative symptoms (Kirschner et al., 2017), which may be the reason for the change of appearance of women from Malak's perspective. However, the word she used is stigmatising and reveals her thoughts about women with negative symptoms.

Samantha from Hospital B also identified women as *schiz*, *psychotic*, and *bipolar*, reflecting a labelling and stigmatising approach. She also added some views representing her experience of stigma, in terms of seeing the women as helpless and feeling sorry for them:

Norah: Let's go deeper into...negative attitudes toward women with psychosis care.

Samantha: ...Because of this condition [psychosis], and you know they are helpless. I feel so sorry for them ... it is not fun that they are alone because this is the condition they are chased for [treatment], and we help them to deal with that.

Norah: And you said [previously] that your responses are the same, and you deal with them equally.

Samantha: Equally. We do not give the [consumer] special care because she is (schiz.) [sic.], psychotic...bipolar, no, we just treat them equally. (p. 2, lines 67-73)

Samantha highlighted her readiness to deliver better care to women. However, labelling the consumers as *schiz*, *psychotic*, and *bipolar* reveals stigma, as in the cases of Malak and Sophia. Samantha added that she thought that women with psychosis were helpless and felt sorry for them. A possible reason for this feeling may be that the community views individuals with mental illness as weak, which is reflected by nurses who inherit these feelings from that community. While Samantha reflected on how this sympathy for women could impact her care, this type of sympathy might undermine the care provided. The nurse may not allow women to make decisions about their care, as they are viewed as incompetent and unable to help themselves. Happell, Ewart, Bocking, Platania-Phung, and Stanton (2016) found that health professionals viewed consumers with mental illnesses as incompetent to make decisions about their health and lacking insight due to the diagnosis of mental illness, attitudes which represent forms of stigma. Samantha's, Madeeha's, and Manahel's perspectives suggested disempowering women and viewing them as helpless, which means nurses adopted a service-based recovery approach in nursing care (Schrank & Slade, 2007).

Overall, the nurses' perspectives in this sub-theme illustrated multiple forms of stigma while providing the care women with psychosis. Their embodied experiences, thoughts, feelings, responses, and relationships that reflected stigma were investigated by van Manen's (2014) lifeworld existentials of lived self-other and lived body.

Nurses' expressions of stigma noted in this sub-theme might influence the nursing care provided to women with psychosis. The stigmatisation of women as helpless or childish is assumed to disempower women's autonomy and reflects a service-based approach to recovery (Schrank & Slade, 2007). Therefore, it may be helpful to develop some guidance and recommendations on how mental health nursing professionals can overcome stigma and deliver more inclusive care to women with psychosis. In-service education promoting stigma-reducing programs, including inviting individuals with mental illnesses to speak to staff and simulations to promote non-judgmental communication and non-stigmatic clinical interactions with consumers with mental illness, may be helpful (Ordan, Shor, Liebergall-Wischnitzer, Noble L, & Noble A, 2018). Moreover, possible factors contributing to stigma and discrimination by nurses include a lack of education and training on mental illness in undergraduate nursing programs (Vandyk, 2015). It may be worthwhile for academic institutions to offer more intensive theoretical and practical preparation for nurses before graduation to help them learn how to relate to consumers with mental illness to decrease the incidence of stigma.

Some nurses expressed stigma in this sub-theme while providing care to women with psychosis. The next sub-theme explores the nurses' experiences of social stigma against caring for women with psychosis by families and communities; this experience also affects the care provided by nurses to these women, as discussed in the following sub-section.

10.4.2 Subtheme 2: Social stigma

Social or public stigma has three aspects: stereotypes, which are negative beliefs about particular groups; prejudice, which is a preconscious agreement with such beliefs leading to adverse emotional reactions such as anger or fear; and discrimination, which is negative behaviour in response to prejudice which may include avoidance, withholding of employment and housing opportunities, withholding of help, coercive treatment, or segregation (Corrigan & Watson, 2002). Social stigma toward consumers with psychosis was reported by Pescosolido, Monahan, Link, Stueve, and Kikuzawa (1999), with over 40% of their public sample agreeing that individuals with psychosis should be forced into treatment. The factors contributing to social stigma include media depictions in films and books which identify individuals with mental illness as homicidal maniacs who must be feared or who have childlike perceptions of the world that should be marvelled at (Wahl, 1995). In the media, individuals with mental illness are often thought to be responsible for their illness due to character weaknesses (Wahl, 1995).

In the present study the nurses reported facing the same attitudes from the families of women with psychosis, which may affect the care they provide. Moreover, negative social views of mental health nursing as a profession might also influence the motivation and quality of nursing care. Sarah illustrated how social stigma in some families was identified as hindering care, mainly where it caused families to neglect or avoid women with psychosis: ‘When the families come and see them [women with psychosis], they [families] neglect them [women with psychosis], and they feel stigma from their families’ (p. 3, lines 100-101). Sarah added that these families also shun communication with and withhold help from nurses working to care for women ‘about 25% [of the time], you feel like there is a stigma between families that affects our communication [with them]’ (p. 3, lines 114-115).

This view of family avoidance and withholding help and the effects on nurses' care for women with psychosis reflects the impact of family stigma on mental illness. Family stigma negatively affects the recovery of consumers with mental illness because they may avoid treatment (Park S & Park KS, 2014). Avoidance and non-engagement with women's care, as mentioned by Sarah, challenge user-based recovery (Schrack & Slade, 2007).

In addition, general social stigma of mental health issues influences nurses working with mental health consumers. This stigma caused Ahd to feel afraid to care for consumers with mental illnesses at the beginning of her career:

Once you get this employment, you find yourself surrounded with societal ideas that consider ... [a] mental health consumer [to be] an insane person. They used to feel pity for me [because] I work in this field. Moreover, in the beginning, I felt afraid [because of this view]. (p. 2, lines 58-60)

Ahd felt that the general social stigmatisation of mental health also tarnishes the image of nurses working with mental health consumers and made Ahd afraid to care for women with psychosis at the beginning of her career. A study in the KSA context by Alshowkan (2017) explored nurses' attitudes in KSA to their care of individuals with mental illnesses, and identified some factors affecting nurses' attitudes. One significant factor is the social factor, encompassing stigmatisation of consumers with mental illness in society, which makes it difficult for nurses to build positive attitudes to their profession (Alshowkan, 2017). This attitude made Ahd afraid of caring for women with psychosis at the beginning of her career.

Overall, two perspectives of nurses encompass their experiences of social stigma to caring for women with psychosis. These perspectives reflect the essential nature of accounting for family influences on nursing care and accounting for ways in which societal stigma may impact nurses' care due to negative perceptions of nurses caring for consumers with mental illness. The relationship of nurses with consumers' families and negative societal views of

mental health nursing which affected nurses care were understood using the lived self-other existential of van Manen (2014).

Sarah confirmed avoidance and non-engagement with women's care, challenging user-based recovery (Schrang & Slade, 2007). She identified a gap that can be addressed by educating families about the illness and its treatment, emphasising the importance of their support and engagement in their relative's care. Regarding social stigma, it may be worthwhile for nurses to be made aware of this social stigma to improve the care provided to women, and nurses can use their position of trust among the public to find opportunities for advocacy to end such stigma (Happell, 2005). As communities tend to have a high level of respect for nurses, it may be hypothesised that contact and education interventions administered by nurses working in areas of mental illness may promote stigma reduction (Pinto-Foltz & Logsdon, 2009). If facilitated by both hospitals in this research context, such interventions might help nurses play an influential role in reducing stigmatisation of mental ill-health and improving the care provided to consumers with psychosis.

10.5 Summary

This chapter has explored the experiences of nurses working in KSA while providing care for women with psychosis and how they relate to others. Nurses' experiences of relationships while caring for women were explored using van Manen's (2014) lifeworld existential: lived self-other. Some nurses' embodied experiences of feelings, thoughts or behaviours potentially related to their relationships with others were understood through the lived body existential (van Manen, 2014).

The theme of *family* explored how nurses view the provision of education for the families of consumers, a process currently limited in both hospitals, but if applied, could improve the

care provided to women with psychosis. Moreover, family education about psychosis might reduce unrealistic expectations of the illness, disagreements, and conflicts between nurses' and families about the illness and the care provided due to their misunderstandings of psychosis.

The theme of *relationships* was divided into four sub-themes. Nurses' experiences of relationships with colleagues showed these relationships to be crucial for providing care, mainly when conflicts and lack of collaboration with other mental health teams arise.

Experiencing relationships with managers was viewed by nurses as critical, as appreciation could motivate nurses to provide better care. Providing care to women where there are language differences has been suggested by expatriate nurses as an area that requires attention. These nurses noted this area was challenging and required hospitals to provide translated materials or interpreters for nurses. The last sub-theme in *relationships* highlighted how some nurses viewed specific symptoms of psychosis as complicating their relationships with the women in their care, such as in cases where women mistrust nurses, which hinders both communication and care.

The final theme examined in this chapter was *stigma and discrimination* while providing care to women with psychosis. *Nurses' experiences of stigma* when providing care were represented by nurses' dislike of caring for women with psychosis, based on assumptions that they were childish and helpless, labelling them by their illnesses or symptoms or feeling sorry for them. These views were likely to impact nurses' relationships with women negatively and, therefore might affect the care provided. Moreover, some experiences that stigmatise women as helpless or childish might disempower women's autonomy by nurses providing more care, a service-based recovery approach to care (Schrank & Slade, 2007). A sub-theme, *social stigma*, was also attached to the care provided to women. When a family avoids their

relative and withholds help, and does not communicate with nurses about care, this also impacts the care provided by nurses. Therefore, education and engagement with families are elements of a user-based recovery approach (Schrank & Slade, 2007), reducing stigma in women's families. Societal stigmatisation of the mental health care profession causes some nurses to experience negative feelings when caring women with psychosis, mainly being afraid to provide such care at the beginning of their careers.

This chapter was the last theme presenting the nurses' experiences of caring for KSA's women with psychosis. This next chapter examines the experiences of women with psychosis, including how they experience the care provided by nurses.

Chapter Eleven: KSA Women's experiences of living with psychosis and being cared for

11.1 Introduction

This chapter presents an analysis of individual semi-structured interviews with women living with psychosis. A total of 21 women with psychosis from Hospitals A and B participated in the research, and thirteen of the interviews were audio recorded, allowing direct quotations to be used as evidence. The remaining eight women were not audio recorded (see Chapter Six: *Interview sessions*), as Hospital A did not permit audio recording on the premises. Extensive field notes were therefore taken. In addition, some notes and drawings were created by women whose interviews were not audio recorded, to capture their views on their phenomenological experiences. While field notes were taken as accurately as possible, they do not permit direct quotation, which is acknowledged as a limitation to some of the findings in this chapter.

The women's accounts were analysed using van Manen's (2014) six lifeworld existentials: lived space, lived body, lived self-other, lived time, lived thing, and lived cyborg. Five drawings and notes of women were also explored using these existentials. However, in the pre-analytical stage of interpreting the findings phenomenologically using these existentials, the vocative analysis method of van Manen (2014) was used. This method revealed the meanings embedded in these texts and helped to understand the essence of the women's experiences.

This chapter addresses three major themes (see Table 11.1) (1) *Women in KSA and their lived experiences of first-episode psychosis*; (2) *KSA women's experiences of living with psychosis*

after admission to or on follow-up from a mental health facility; and (3) KSA women's experiences of living with psychosis in the community after discharge from a mental health facility.

Table 11.1: The major themes representing KSA women's experiences of living with psychosis and being cared for

KSA Women's Experiences of Living with Psychosis and Being Cared for	
Theme 1	Women in KSA and their lived experiences of first-episode psychosis.
Theme 2	KSA women's experiences of living with psychosis after admission to or on follow-up from a mental health facility.
Theme 3	KSA women's experiences of living with psychosis in the community after discharge from a mental health facility.

As the literature review showed, Alyahya et al. (2022) highlighted the importance of applying an exploratory approach to the experiences of women with psychosis in relation to the impact of culture and gender on these experiences. Nxumalo Ngubane et al. (2019) also sought to advance knowledge of what it is like to be a woman from a particular culture (Swazi) experiencing psychosis. The women in the study of Nxumalo Ngubane et al. (2019) highlighted their emotions, based on perceiving they had an illness, while also experiencing pain about their relationships with others, who label women with the illness and do not show care for them; however, the women also expressed how they improved and recovered despite such challenges.

However, a broader examination of KSA women's experiences with psychosis has been overlooked to date, and this area requires further exploration. This chapter is a starting point to exploration of this area.

11.2 Theme 1: Women in KSA and their lived experiences of first-episode psychosis

The first theme identified involves their experience of first-episode psychosis. The women's views of their experiences were clustered and analysed using the five lifeworld existentials of van Manen (2014): the lived body, lived self-other, lived time, lived thing, and lived cyborg. Details of how these existentials were identified each sub-theme are discussed in each sub-section, as the theme of experiencing first-episode psychosis is divided into two sub-themes: *understanding of the cause of psychosis* and *experiencing the onset of psychotic symptoms, with developing insight into the illness*.

First-episode psychosis refers to the first time someone experiences a psychotic episode (Koutra, Vgontzas, Lionis, & Triliva, 2014), and usually occurs in late adolescence or early adulthood, which is often a time of significant change and upheaval, but crucial for developing identity, independence, sexuality, intimate relationships, study, and career plans (Harris et al., 2005). For some women a first episode of psychosis could occur during the perinatal period, in which the onset tends to be rapid and where daily functioning is most commonly severely affected (McGrath et al., 2013). An interesting point about some women's experience with the first episode of PPP in McGrath et al.'s (2013) study is that once some women understand they have a mental health problem, they tend to conceal it from or minimise sharing of their problems with their informal support networks. Some women reported that their thoughts and feelings did not correspond to their experiences, with such responses driven by factors such as a fear of hospitalisation and loss of child custody, often accompanied by fear of exposure and feelings of guilt and shame (McGrath et al., 2013). McGrath et al. (2013) explored only one type of psychosis, PPP; however, it offers some insights into women's experiences when an illness begins and an overview of the

factors contributing to it. In the KSA context to the best of my knowledge, no previous study has explored women's experiences of first-episode psychosis, and the women's views about first-episode psychosis reported in this research are the first in the KSA context.

11.2.1 Sub-theme 1: Understanding the cause of psychosis

The women's views revealed their understanding about causes of psychosis and were investigated using the lived body existential. The interviewees revealed the point of time in their lives: adolescence and young adulthood, in which the first episode of psychosis started; these experiences were explored by lived time. In these times, women experienced some events that caused first episodes, which were understood with the lived things (van Manen, 2014).

According to McFarlane, Lynch, and Melton (2012), the cause of psychotic illness is related to the interaction of biological susceptibility represented by specific biological problems of the brain with environmental stressors which cause or exacerbate the onset of psychosis. Psychosis is generally induced in biologically vulnerable individuals by significant life stresses, often imposed by role transitions and similar major life events, social isolation and rejection, family conflict, separation from their family of origin, or stigma (McFarlane et al., 2012). In the literature on women's experiences with first-episode psychosis, McGrath et al. (2013) focused on PPP when examining women's views about the causes of psychosis. The women in that study believed that biological factors such as hormones and genetics were the main reasons for psychosis; where such factors exist alongside significant stressors, the stressors could trigger psychosis (McGrath et al., 2013). Some women interviewed for the present research similarly cited life stressors in adolescence as triggering their psychosis.

Adolescence generally coincides with the age at which young women attend high school, and such attendance can lead to many problems. For example, Zahra suggested her struggle to

cope with the stress of exams led to her initial experience of psychosis. She illustrated her experience of various stressors at high school with stories about her teacher and the exam which preceded her first episode:

In high school, it [was] a significant event for me, a history teacher forced me unusually [to do challenging tasks and] she made me sick, as you do not know any reason for that, May Allah guide her.... She said to me, 'why you do not care [about doing assignments]? See what your classmates did'... The teacher did not care [about feelings], was mocking and shouting at me, so I hated her and withdrew from the situation.... As a result, she became frustrated, as I did not show that I was affected by her shouting and ignored her.... Finally, I failed history, [and] it was [a serious] matter because it was my first time failing. My grades were Excellent or even Very Good [previously], it was my biggest shock, and I felt heaviness in my chest.... She [History teacher] did not make me pass the exam. I was afraid and nervous [before the results] and asked [the school officers] about what had happened in History: 'Have I passed?' They said to me: 'We are still working on the reports, go for now and come back tomorrow'. They did not want to shock me, but they were preparing me for that failure... I came back in the next day, and they told me that I failed... [Next year], I felt shy, as I was sitting between students [who were] younger than me, and all my classmates went to another grade while I still at the same grade, feeling I cannot acknowledge this failure. (p. 2, lines 56-87)

As Zahra points out, exposure to stressful life events at school is a significant predictor of the onset of psychosis. Stressful situations such as school exams often represent an accumulation of learning activities, which Silva et al. (2019) argue can lead to physical and mental exhaustion; such activities are often considered a trigger for psychosis. Likewise, reduced academic performance and problems with adaptation to school are symptoms of poor premorbid adjustment, which is a known factor in risk prediction for psychosis (Ramirez et al., 2010; White et al., 2009). Such studies make sense if we reflect upon Zahra's identification of stressors at school driving her to experience her first psychotic episode during her high school examinations.

Unlike Zahra's focus on school stressors, Joud took a broader view, identifying her first-episode psychosis as arising from an accumulation of stressors:

Maybe it is because of study or social pressure; there was no significant incident, but little [accumulated] things. Maybe over time [these things] caused me these symptoms. I lost control of myself, and I did not know the [exact] reason; I did not have a big problem happen to me or anything like that, only my high school study pressure and problems with my friends. I was a sensitive person, and I hid my problems and pressures: [over] time these [problems] caused me these symptoms. (p. 1, lines 14-19)

Zahra discussed her experiences related to high school stressors and the problems that occurred in her adolescence in detail, including an occasion when her teacher criticised her, which she associated with her first experience of failing an exam. In contrast, Joud's view of her experience of psychotic onset was broader, touching on a range of possible causes for psychosis. However, she mentioned her vulnerability and sensitivity, suggesting these may impact over time, based on the accumulation of multiple stressors. Both Zahra's and Joud's descriptions of events preceding the onset of psychosis are consistent with Goodman et al. (2001), who revealed that individuals with psychosis tend to have high rates of stressful and traumatic experiences before the first episode of psychosis. The pattern of criticism by a teacher and exam failure in Zahra's situation and the accumulated stressful experiences noted by Joud support this argument.

Some other interviewees believed the causes of psychosis have metaphysical aspects, concerning magic and the evil eye. This aspect was illustrated in the field notes representing Eliana's perspective; she suggested that the first hallucination came two days after her marriage when her sister-in-law and sister made magic, using smoke and amulets to cause her to see people who scared her.

Another woman, Safiya, believed the evil eye caused her illness:

While I was abroad, some people saw me, [and because the people who saw me had] not mentioned the name of Allah, an evil eye haunted me, and I faced this hardship at the age of seventeen. I had a dream in which I saw all the people attacking me with their evil eyes. (p. 1, lines 21-25)

Eliana and Safiya viewed metaphysical aspects as causes of their first psychotic episodes. Metaphysical explanations of mental illness have been explored in research related to Muslim women with mental illness, including an exploratory study by Lim, Hoek, Ghane, Deen, and Blom (2018) in a transcultural mental health outpatient clinic with several female Muslim participants. These women were asked whether mental health symptoms had metaphysical causes (the evil eye, magic, or jinn), and a significant number of consumers confirmed that they believed in such causes of mental illness (Lim et al., 2018). Ethnic Arab consumers tend not to focus on the origins of illnesses from a biomedical perspective, instead assigning them to an external locus of control, which is often supernatural (Al-Krenawi & Graham, 2000). In KSA, as discussed in Chapter One, Arabic and Islamic metaphysical concepts are frequently applied to explain mental illness, including magic, malicious envy, the evil eye, or possession by *Jinn* (Badawi, 2016), often represented by beliefs in magic and the evil eye, as seen in Elaina and Safiya's situations. When Eliana and Safiya, who came from Islamic backgrounds, considered the causes of the onset of psychosis, they considered metaphysical causes most likely, reflecting their cultural understanding of mental illness as a metaphysical ailment.

Specific family problems, such as forced divorce, were also viewed as causes of psychosis; Salma's view illustrated this. The field notes on her perspectives show that she mentioned that her ex-husband's problems with her family pushed the family to ask her husband to divorce her, although she still loved him and refused to acquiesce to the divorce, based on her wish to raise her son with her ex-husband. After the divorce, when she was 24 years old, she started hallucinating about her older brother, who was the main reason for her divorce. She said she heard his voice threatening her.

Salma experienced a forced divorce as a young adult, and McFarlane et al. (2012) argued that romantic and marital losses for women are among the most potent events triggering the onset of psychosis. It is also widely acknowledged that the trauma caused by the cessation of romantic relationships can lead to psychosis in some individuals (Silva et al., 2019). These claims may explain that the stressor of Salma's relationship ending was the cause of psychosis.

The perspectives in this sub-section reflect the experiences of these women and offer insights into what they perceived to be the causes of psychosis. The women revealed their understanding of events which caused first-episode psychosis, which started in adolescence and young adulthood; all these perspectives were revealed using van Manen's (2014) lived body lifeworld existentials.

School exams and ongoing stressors such as accumulated life pressures and forced divorce offer insights into the causes of psychosis that some of the women perceive. However, some women focused on metaphysics, represented by magic and the evil eye, as causes of psychosis, which may represent a lack of understanding of the causes of psychosis. Such insights may help develop ways to manage psychosis through psychoeducation based on early intervention, where individuals are identified as possibly vulnerable to developing psychosis, such as having close relatives who have experienced psychosis (Early Psychosis Guidelines Writing Group [EPGWG], 2010). The prodromal stage of psychosis, which is usually a long period preceding the formal onset of psychosis with increasing symptoms and functional decline, underlines the importance of early intervention by mental health professionals to prevent disruption to consumers' psychosocial development (Koutra et al., 2014). Supportive counselling: an early intervention by mental health professionals for individuals and their families to assist them to manage significant stressors, such as Zahra's

exam stress, may have been helpful to slow or halt the onset of psychotic symptoms and to improve individual functioning and optimise recovery ([EPGWG], 2010; Wong, Shahwan, Verma, & Subramaniam, 2019). However, in the researcher's experience, despite having worked with KSA's mental healthcare system for many years, I have not seen evidence of any service which identifies individuals as vulnerable to the development of psychosis. Government and mental health facilities may seek to make the initial steps to create campaigns to increase knowledge in the community about ways to recognise whether a family may have some individuals vulnerable to developing psychosis. If families cannot identify loved ones with such vulnerabilities, it may be worthwhile for mental health facilities to organise more general advocacy services to support the mental health of adolescents and young adults, the typical ages for developing psychosis. These services will help them learn how to manage significant stressors in their lives, such as coping with failure in exams or relationship breakdowns.

In this sub-theme, some women discussed their initial understanding of the causes of their first episode of psychosis. Some expanded on their experiences with the onset of psychotic symptoms in the next sub-theme.

11.2.2 Sub-theme 2: Experiencing the onset of psychotic symptoms, with developing insight into the illness

Van Manen's (2014) existentials helped identify this sub-theme. The women's understandings of and insights into the onset of symptoms were all investigated with the lived body existential. Again, in this subtheme, experiencing the onset of these psychotic symptoms at adolescence and early adulthood was investigated with lived time. As these psychotic symptoms emerged, some women experienced the impact of their relationships with others, particularly their family, in the development of the symptoms, and the lived self-

other helped to understand these impacts. At this stage of psychosis, technology was part of the psychotic symptoms in some experiences, with the idea of being tracked by someone with her phone, laptop, and TV; the lived cyborg assisted the revelation of these experiences (van Manen, 2014).

The onset of psychotic symptoms is unique for each consumer. The literature review examined a qualitative study by Henderson and Cock (2014), who described common behavioural symptoms of young individuals during the first episode of psychosis. The actual experience of individuals was reflected in their psychosocial behaviours, as they lost control in ways disruptive to their lives and those surrounding them (Henderson & Cock, 2014). For women with first-episode psychosis, however, the literature focuses on PPP, in which onset generally occurs rapidly after delivery of the baby and where functioning is severely affected (McGrath et al., 2013).

Regarding the development of insights into psychosis, David (1990) described insight into psychosis as a set of descriptive beliefs with three distinct dimensions: awareness and recognition of having a mental illness; awareness of the need for treatment and adherence; and capacity and ability to recall and relabel psychotic symptoms (delusions and hallucinations) as pathological. Insight into psychosis can help consumers improve and recover in the early stages of psychosis (Campos et al., 2011). McGrath et al. (2013) spoke with women who discussed the positive impacts of developing an understanding of and insight into early postpartum psychotic symptoms and overcoming the illness and facilitating recovery. However, lack of insight has been seen as a cardinal feature of psychotic illness (López-Moríñigo et al., 2014). It has been argued that lack of insight leads to avoidance of care and increases the duration of untreated psychosis (Drake, Haley, Akhtar, & Lewis, 2000).

Some women in the present study were willing to discuss in depth their experiences with first-episode psychotic symptoms. The symptoms commonly started in adolescence. Zahra described in the previous sub-theme how the stressors of high school were leading causes of psychosis. In this sub-theme, she also described how initial delusional belief began to build up in her mind as she sat her final exams in high school: ‘My [delusional] thoughts took their first steps, and I started connecting these thoughts [as] my final exams for the first high school year for the second time [after resitting the year] started’ (p. 4, lines 184-185). She then described her experience of the development of psychotic symptoms during her exams:

After two or three days during the exam time, a girl came and talked to me in the square at school, with strange words.... I do not remember the conversation exactly, but I remember that talk was powerful and unfamiliar, [and I felt that] that unfamiliar talk should be considered [had an impact] throughout my life.... Then, she started engaging me in other matters, [discussing] problems in the world and at the level of the Ministry of Education, which appointed personnel for security surveillance in the school. After that talk, I went to class. When I saw that girl, I began shouting and saying, ‘How could you say that?’.... I got sick and lost my mind crying and entered the principal’s [office] because of my fear...I remember that the principal asked me, ‘What’s the matter with you?’ She asked me [to answer] and [then told me] to be quiet while I was shouting...it was the first episode of psychosis [that] happened to me, and then relapses followed. (p. 5, lines 205-223)

Zahra’s thoughts about her understanding of the causes of psychosis were discussed in the previous sub-theme, and her insights into the symptoms she had during the onset of illness are highlighted in this sub-theme. She was aware of psychosis, and showed the capacity to recall symptoms as pathological, reflecting her insight into these symptoms of the onset of psychosis. In addition, she highlighted how her relationships with a girl at her school and the school principal impacted that first episode.

Lama did not use the term psychosis; however, she spoke about hearing voices at the onset of illness in a manner which highlighted her insight into psychosis, affirming that the hallucinations were related to the illness:

I used to hear many voices telling me to sit down. These voices seemed to be normal as if ... coming from an existing person. For example, when I tried to sleep at night, I felt like someone had just entered and closed the door. When I went to the hall, I heard a sound telling me to sprinkle some pepper in my niece's eyes. I used to struggle not to follow [these orders] ... actually, I did not know what I was doing. These voices made me disturbed and nervous, [and] I realised that these voices were related to my illness and not actual. (p.1, lines 23-29)

Abeer also discussed her experience of the onset of delusions and hallucinations, highlighting her insight into having psychosis:

[During] my second year [of university], the symptoms of this illness started to emerge. I started to feel as someone was watching me.... a Devil started to haunt me, I [had a] feeling that I was a unique person and inflated myself. I felt that I was under the spotlight, and everyone loved me. Meanwhile, I felt that, because everyone loved me, some girls [began] to envy me because I became a great person, [very] religious, performing prayers or [making people smile]. ...because I got the complements...at that time, I felt [as though] someone was watching me. In the beginning, I felt that someone was tracking my mobile phone, then my laptop. After that, I felt that someone was hacking [into my laptop] and talking to me. Even when I switched on the TV, I felt as if someone was tracking me. (p. 1, lines 15-25)

Abeer's words show her insight into the onset of psychotic symptoms with thoughts of being watched, tracked, and hacked. The idea of being tracked by someone through her phone, laptop, and TV may explain the impact of technology on the content of psychotic ideas in Abeer's situation, and hearing someone who was hacking her laptop talking to her can be understood as an auditory hallucination. She illustrated how the thoughts impacted her relationships with the community, framing herself as an admirable, lovely, and influential person, which was part of the escalation of the delusional beliefs. These thoughts might be considered grandiose and persecutory beliefs. Grandiose beliefs are revealed when individuals believe in being central, while persecutory beliefs are when they are being tormented, followed, sabotaged, tricked, spied on, or ridiculed (APA, 2013). Abeer's statement reflects the belief of being followed and spied on and may be identified as

persecutory thoughts. Her awareness of these beliefs and hallucinations highlights her insight into the illness.

These quotes of Abeer and Zahra illustrate the fact that psychosis started at school and university. In addition to the teacher and exam stressors in Zahra's situation, stressors also related to the learning environment and space. This issue was explored by Kranke, Jackson, Taylor, Anderson-Fye, and Floersch (2013), who noted that students with psychosis tend to feel overwhelmed by excessive sensory stimuli, such as the noise in a large lecture hall, or by unusually bright lighting. They may also find it challenging to stay alert for long periods, particularly in lecture-style courses which involve little interaction or infrequent breaks (Kranke et al., 2013). This perspective makes the onset of psychosis for adolescents and young adults challenging in learning spaces and adds a potential difficulty for women like Zahra and Abeer.

The first episode of psychosis is often viewed as a point when fundamental changes in family dynamics and systems may be observed, generally over a few months following the episode as family members adapt to the illness (Koutra et al., 2014). Cotton, Gleeson, Alvarez-Jimenez, and McGorry (2010) further demonstrated that the high family burden of a member experiencing first-episode psychosis is associated with a reduction in the consumer's quality of life after recovery.

Nadia discussed her experience of hallucinations at the onset of psychosis in relation to the impact of her family; her family did not support her and would not listen to her when she sought to discuss her hallucinations: 'I could not speak [about hallucinating] because of the family's psychological pressures. My family did not support me when I started to see things [hallucinations] and think a lot' (p. 1, lines 15-17).

Nadia demonstrates her awareness of distress with the onset of hallucinations, and refers to her family's influence on her experience of onset of psychosis, based on a lack of emotional support when she was experiencing hallucinations. Boydell et al. (2014) found that high levels of negative caregiving experiences are associated with families of consumers experiencing first-episode psychosis. This negative caregiving experience was illustrated when Nadia's family did not offer support to her when she was experiencing stressful hallucinations.

The examples above illustrate the experiences of KSA women with psychosis at the onset of illness. Some highlighted insights into symptoms at that stage of psychosis. Women's experiences of symptoms and insights into early psychotic episodes at adolescence and early adulthood and the impacts of relationships and technology were explored using van Manen's (2014) lifeworld existentials.

Some women's insights during the initial onset of psychotic symptoms indicate that the support of mental health professionals at that stage to assist with managing and recovering from these episodes may have been helpful (Campos et al., 2011). Families both can and do play a significant role in the recovery efforts of consumers experiencing first-episode psychosis. Families may be encouraged and educated by mental health professionals to become therapeutic agents supporting the process of consumers' psychosocial rehabilitation (Koutra et al., 2014). This step might help families such as Najat's learn how to calm and support relatives who show the onset of psychotic symptoms.

Overall, the experiences of KSA women with first-episode psychosis revealed two sub-themes. The first reflected their understandings of possible causes of first episode psychosis, and the second reflected women's experiences with the onset of psychotic symptoms. Some of the interviewees revealed their understandings of and insights into the events that caused

psychosis and the symptoms emerged at adolescence and in young adulthood, which were affected by relationships with others and technology; these perspectives were investigated using van Manen's (2014) lifeworld existentials.

Their experiences of seeking treatment and care during admission or follow-up from a mental health facility formed the next theme.

11.3 Theme 2: KSA women's experiences of living with psychosis after admission to or follow-up from a mental health facility

The second theme describes the interviewees' experiences of psychosis during their admission to a facility or at follow-up in OPDs. These experiences were understood using van Manen's (2014) four lifeworld existentials: lived body, lived self-other, lived cyborg, and lived space. More details of how these existentials were used with women's perspectives are provided in the following four sub-sections of this theme: *admission or follow up experiences, experiencing psychotic symptoms and insight into psychosis after admission, experiences with services and nursing care, and the need for a healing space* (see Table 11.2). A drawing and three notes in this theme were analysed using van Manen's (2014) vocative analysis method to explore these texts to uncover the meanings embedded in the pre-analytical stage before using lifeworld existentials to analyse the texts.

Table 11.2: Theme of psychotic experiences on admission or follow up from a mental health facility and its four sub-themes

KSA Women's Experiences of Living with Psychosis After Admission or Follow-up from a Mental Health Facility	
Sub-theme 1	Admission or follow-up experiences.
Sub-theme 2	Experiencing psychotic symptoms and insight into psychosis after admission.
Sub-theme 3	Experiences with services and nursing care.
Sub-theme 4	The need for a healing space.

11.3.1 Sub-theme 1: Admission or follow-up experiences

Many interviewees with psychosis offered stories of their admission experiences to mental health facilities or their follow-up experiences in mental health clinics. The women's experiences of admission and follow-up and their relationships were explored using the lived body and lived self-other. Living a psychotic experience during admission and being affected by the facility's technology were explored using the lived cyborg existential (van Manen, 2014).

Admission to a mental health facility for consumers with psychosis was examined by Cougnard et al. (2006), who highlighted that the median duration of the first admission with psychosis was five weeks. However, after the first hospitalisation for psychosis, half of the consumers were re-admitted at least once, with a maximum of six re-admissions in two years (Cougnard et al., 2006). The characteristic that significantly predicts an increased risk of re-admission is when consumers display persistent psychotic symptoms at first discharge; the consumers are three times more likely to be re-admitted. However, unemployment also increases the re-admission risk (Cougnard et al., 2006). In terms of contact with mental health professionals and psychiatrists, Cougnard et al. (2006) noted that one of three consumers no longer had contact with a mental health professional two years after their first admission with psychosis and that 38% no longer had any contact with a psychiatrist. These statistics give a sense that it is likely for consumers with psychosis to have initial admission and re-admission to a mental health facility, despite follow-up for the consumers. However, the sub-theme *admission or follow up experiences* focus on the qualitative accounts of what it is like to be a KSA woman with psychosis being admitted to or followed up and having close contact with the mental health facility. Excerpts from some interviews illustrate this focus.

An example of experiencing follow-up in a mental health facility was given by Karima, who noted experiencing deterioration of the illness after her first follow-up consultation with a psychiatrist:

After I felt sick, I went to the doctor in his clinic. On entering...he asked me a question, 'Who are the enemies of Islam?' I was not ready to answer such a question [though] I cared about my religion very well, all praises to Allah...performing all prayers at their due times. All my conditions changed as I left the clinic, and I did not feel anything surrounding me. (p. 1, lines 27-32)

Karima mentioned that when the psychiatrist tried to ask her about her religious thoughts, the illness became worse. While it is not acceptable to make assumptions about this situation, her experience suggests that she had beliefs about religion at the time of her appointment and that the psychiatrist asked her about religious thoughts concerning the beliefs she had. As discussed in Chapter Nine with some nurses who viewed that women's beliefs should be discussed, there is debate as to whether mental health professionals can challenge consumers with delusions or not. However, it is generally suggested that mental health professionals avoid discussing consumers' delusions to avoid collision with consumer beliefs (McCabe & Priebe, 2008). This collision can be seen in Karima's example: when the psychiatrist asked her about her belief, her beliefs made the illness worse. Instead, when speaking with a consumer presenting distress due to false beliefs, mental health professionals should anticipate acknowledging the consumer's distress and suffering without directly reinforcing their beliefs by asking more about such beliefs (Lepping, Huber, & Freudenmann, 2015).

Some women understood that a relapse indicated a need for re-admission. Based on field notes from Hamida's interview in the inpatient ward, she noted that her most recent admission was two months previously, and the cause of the admission was that she could not perceive reality, causing her to destroy her kitchen. The field notes for Alya noted her recent admission to Hospital A was about one month previously, and this arose after her psychiatrist

changed her dosage of antipsychotic medication, leading her to attempt suicide by drowning. She was aggressive on arrival at the emergency room and had visual hallucinations: she described seeing a bright hole in the roof, through which she could see the sky, and believed that the brightness was God who had come to help her.

Hamida's and Alya's recounts of their experiences reflect their understanding that the relapse of psychosis with severe symptoms required them to be admitted to the hospital. In Hamida's situation, relapse was related to detachment from reality and impulsivity, shown in her destruction of her kitchen. Alya reported attempting suicide before her current hospital admission. A relapse of psychosis can be identified by severe clinical symptomatology, such as episodes of self-harm (Taylor, Ravesteyn, Lambregtse-van den Berg, Stewart, & Howard, 2016), as in Alya's situation. Alya further highlighted that her severe relapse was triggered by a change in the dosage of her medication; switching or discontinuation of medication is similarly a predictor of relapse (Taylor, Broadbent, Khondoker, Stewart, & Howard, 2018). Relapse with psychosis often requires admission to inpatient acute care (Taylor et al., 2018), and both Hamida and Alya recognised that they needed to be admitted due to relapse.

Joud viewed the period surrounding her first admission to the hospital as complex because of the delusions and subsequent feelings of shame, as she discussed her involuntary admission:

When I [was] admitted to the hospital [for the first time], I had delusions; maybe I had them before, but I do not remember. I imagined things that happened to me when I was admitted to the hospital: I felt that people watched me and that was on the TV. When I was in the hospital or the street, I felt people thought I was an abnormal person, so they looked at me in such a way. I felt ashamed. All this was before [I was admitted] to hospital and forced to [that] admission. I could not understand the situation; I thought the police arrested and punished me and [wanted to] kill me. (p. 1, lines 24-30)

Joud's description illustrates the acute stage of psychosis, which preceded and followed her initial admission to the hospital. She believed that everybody was watching and following

her, revealing that she might have persecutory ideas and beliefs (APA, 2013). The impact of technology such as TV was revealed in Joud's thoughts about persecution and being watched by people on TV. Furthermore, the persecutory delusions were compounded by her involuntary admission. According to Cougnard et al. (2006), almost 62% of consumers with psychosis are subject to involuntary first admission. These numbers indicate that involuntary admission is a common experience for consumers with psychosis such as Joud. Involuntary admission caused her to believe that admission was related to the police arresting her to sentence her to death. While Joud did not specifically mention her perspective on compulsory admission to manage acute persecutory thoughts, her description of her experience suggests that the delusions were exacerbated and reinforced by her forced admission.

These examples of the experiences of KSA women with psychosis regarding admission to or follow-up in mental health facilities were narrated by women after asking them about their experiences of psychosis generally. Therefore, these specific experiences suggest a certain level of importance to these women about reliving admission and follow-up experiences. The women reported a range of feelings, thoughts, perceptions, and understandings about relapse followed by admission (Hamida and Alya), involuntary admission (Joud), and a first follow-up appointment with a psychiatrist (Karima). These experiences were understood with the lived body existential (van Manen, 2014). The women's relationships were revealed with the discussion of communication with the psychiatrist at Karima's first appointment. After this appointment, her thinking worsened the illness; this experience was revealed the lived self-other. The lived self-other was also applied to Joud's experiences of delusions surrounding her involuntary admission by police. During this admission, she had ideas she was being watched on TV by others; the technological impact on her experience of these ideas was explored with the lived cyborg (van Manen, 2014).

Joud and Karima's experiences highlighted the potential for difficulties when people are admitted to or followed-up in medical facilities. It would be worthwhile for health professionals to be mindful while establishing a therapeutic relationship of developing rapport, demonstrating interest, and encouraging trust with sincere offers of assistance (Keks & Blashki, 2006). This strategy might have been emphasised in the situation experienced by Joud, who had difficulty with delusions during her involuntary admission, which could have been eased with assistance and reassurance by a mental health professional to establish trust and help her work on the delusions.

In the previous theme some interviewees offered views of their experiences of symptoms and insights into the symptoms of first-episode psychosis. In this theme, the next sub-theme *experiencing psychotic symptoms and insight into psychosis after admission* was identified based on women's views about their admission and treatment.

11.3.2 Sub-theme 2: Experiencing psychotic symptoms and insight into psychosis after admission

All interviewees' reports of the symptoms and their insights into psychosis were analysed using the lived body lifeworld existential. Some of these experiences of symptoms were impacted by technology at the facility; the lived cyborg lifeworld existential helped to understand these experiences (van Manen, 2014). One note a woman wrote was analysed using van Manen's (2014) vocative analysis method, a pre-analytical stage of exploring the meaning embedded in this note.

Insight into and knowledge of illness are crucial elements of user-based recovery (Schrang & Slade, 2007). Ramu, Kolliakou, Sanyal, Patel, and Stewart (2019) found that lack of insight into psychosis was recorded in almost half of all consumers with psychosis who participated in the study. This lack of insight was also found in consumers with higher admission

numbers, additional legally-mandated involuntary admissions, antipsychotic agents, and long stays as inpatients (Ramu et al., 2019). This perspective explains the inter-relationship between low insight and admission experience regarding frequency, involuntary type, and length of stay.

In the present study, many interviewees revealed their insights into psychosis and their experiences of having psychotic symptoms after admission. For example, Jana mentioned that she had delusions and described the illness on admission: '[Concerning] magic, I was suffering from [a] relapse when the delusion [about magic] attacked me, and I believed the delusion. I suspected [the] doctors and nurses [of] magic. [Concerning] envy, I doubted my relatives [envied me]' (p. 1, lines 30-32).

Jana's comment reflects her insight into mental illness based on her awareness and appreciation of the psychopathology of illness (Ramu et al., 2019). However, Jana's comments about the suspicious thoughts of others doing magic to her may not represent complete insights into psychosis.

Joud also talked about ideas of reference after admission:

In my room in the hospital, I heard the TV sounds coming from the hall, but I heard different words. I heard [others] speaking about me and laughing at me. When I heard someone talking, I thought they were talking about me: I used to hear sounds and explain them in another way. (p. 1, lines 31-33)

Joud showed her awareness of illness in her discussion of the symptoms she experienced underlying her first admission. She described thoughts and perceptions that people on TV and around her were talking about her, which indicated the impact of technology on Joud's experience of psychosis. Her experience, in general, might indicate ideas of reference. Ideas and delusions of reference are among the diagnostic criteria for psychotic illnesses, and occur when an individual experiences random events and coincidences and believes that

these have personal significance, despite the lack of evidence (Kiran & Chaudhury, 2009).

One typical example is when people think that strangers are talking about them (Adams & Sutker, 2007), as mentioned by Joud.

Dalia and Halima, who were admitted to Hospital A, expressed their experiences of illness in different ways. Field notes on Dalia show that she discussed her experience of symptoms without viewing them as part of psychosis. Dalia heard an unknown man state that her brother had called her *Satan*. She added that other consumers and nurses had labelled her as an unbeliever (a reference to heresy in Islam). Dalia said her body was dead and had flown up to God, but she did not know whether God would forgive her or not. She wrote about her thoughts (Figure 11.1); while the spelling was not completely clear, she confirmed what she meant by many of the words. A basic translation of the text is ‘I was a believer [in God], and my weight was 70 kg, and now I [have] lost everything, myself and my kids, how I can satisfy God and thank you’.

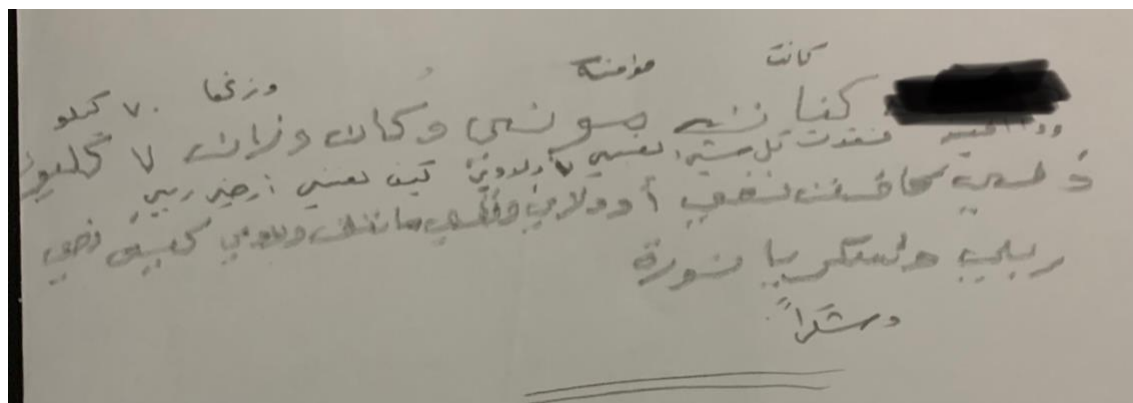


Figure 11.1: Dalia’s writing about her thoughts (some words have been covered to protect the identity of the writer)

Dalia mentioned that she heard a man’s voice, indicating auditory hallucinations.

Hallucinations are shared experiences with psychosis and frequently cause distress, as they can be both frightening and exhausting (Walsh, Hochbrueckner, Corcoran, & Spence, 2016).

In Dalia's situation, the distress at these voices made her exhausted, which might relate to other thoughts of losing everything in her life. She also stated that she was dead, labelled as *Satan* and an unbeliever, and did not know if God would forgive her, highlighting her thoughts that she was a sinner. However, her thoughts about being a sinner and guilty were not necessarily entirely delusional; unfortunately, she offered no further examples, either in the interview or her drawings. Her ideas may reflect a state of sadness, which was apparent in her facial expressions during the interview. However, her views do not reflect insight into her illness, as she did not acknowledge that these hallucinations or thoughts were part of the illness. She did not reflect on the fact that these hallucinations and thoughts were the reason for her admission, as at one point in the interview, she asked the researcher the reasons for her admission.

Field notes on Halima's experience of psychosis during her most recent admission show her complaining of hearing voices talking about people who are monitoring her movements. She repeatedly said that nurses wanted to listen to what she was saying as there was CCTV in her room, which indeed was there. However, the CCTVs in the nursing station were not audio-CCTVs; they were visual only, but Halima thought that the nurses in the station were listening to her. She stressed that one of the consumers was also trying to listen to her; she also claimed that this consumer made others hate her. During our conversation, she sometimes told the researcher that she welcomed her interview, while at other times, Halima told the researcher that she would refuse to complete the interview because there was no benefit to be had from the interview and the researcher was spending her free time chatting.

Halima, like Dalia, offered some insights into hearing voices which indicated she had auditory hallucinations. These voices were of people who monitored or followed her, highlighting the power the voices wielded over her (Holt & Tickle, 2014). The belief about

nurses wanting to listen to her through the CCTV, another woman wanting to listen to her and making others hate her, and the purpose of the interview is to pass the researcher's free time may reflect persecutory ideas (APA, 2013). However, Halima did not show awareness that these were part of the illness, possibly an indication of her lack of insight into psychosis. The presence of CCTV in a woman's bedroom may have reinforced the paranoid ideas.

The interviewees' report of their experiences of psychosis after admission illustrate the symptoms they experienced and their insights into these symptoms. The experiences of symptoms, and insights into these symptoms, and the impact of technology on these experiences were analysed using (2014) existentials. Dalia's note describing her experience of psychosis after admission, was analysed using van Manen's (2014) vocative analysis method to investigate the meaning of this text.

While some women's views of symptoms of psychosis after admission reflected their insights into the illness, health professionals need to provide consumers with education on the illness and their prognosis to reassure consumers about their situations (Doucet, Letourneau, & Blackmore, 2012). The previous examples of women who experienced distressing persecutory delusions, ideas of reference, and hallucinations, reveal their need for reassurance and information. Health care facilities should take all possible opportunities to provide women with one-on-one or group support after admission, in particular, to allow them to share their experiences with others with psychosis (Doucet et al., 2012), as the resulting emotional and affirmational support may aid their recovery (Robertson & Lyons, 2003). Mental health facilities should consider limiting or halting the use of CCTV in the consumers' bedrooms, as they may exacerbate psychotic symptoms.

Insights into the experiences of the interviewees based on mental health facilities' services and nursing care after admission are the focus of the next sub-theme.

11.3.3 Sub-theme 3: Experiences with services and nursing care

The interviewees' thoughts and feelings about services and nursing care after admission were explored using the lived body, while the women's relationships with nurses and other individuals in mental health facilities were understood using the lived self-other (van Manen, 2014). Three textual forms were provided by the interviewees: a drawing and two notes, and in the pre-analytical stage of interpreting the findings phenomenologically, van Manen's (2014) vocative analysis method was used to explore these texts to reveal the embedded meanings.

In relation to the services provided in Hospital B, some interviewees highlighted issues with the mixing of women with different levels of severity of illness in a single unit. Joud said:

The first time I was admitted to the hospital, I saw a consumer holding a knife to cut an orange. She looked strangely at me, [and] I thought she was a criminal. Other consumers [tried to] get to my room and speak with me while I did not know them; it was terrifying. I felt that they were a family and that I was an intruder. (p. 3, lines 100-104)

Karima also expressed the idea that consumers were not separated in terms of the level of illness acuity; she said, 'They did not separate...stable cases and other early-stage cases, which was the most annoying thing' (p. 5, lines 224-225). The experiences of Joud and Karima confirm that consumers were not cared for according to the acuity of their illness, and these views reflect the reality that there were no high-dependency or low-dependency areas in Hospital B. In this context, a high-dependency unit refers to any inpatient mental health area, typically constituting a small number of beds, attached to an acute ward specifically for individuals either posing a significant risk of harm or threat to themselves or others or whose chances of absconding without permission are high (Department of Health, 2002). The lack of separate accommodation in Hospital B is a reason for Joud's fear and Karim's annoyance

during their hospitalisation, as they may have been in contact with consumers with severe symptoms.

Alya, from Hospital A, wrote a poem expressing her feelings about staying in the hospital (Figure 11.2).

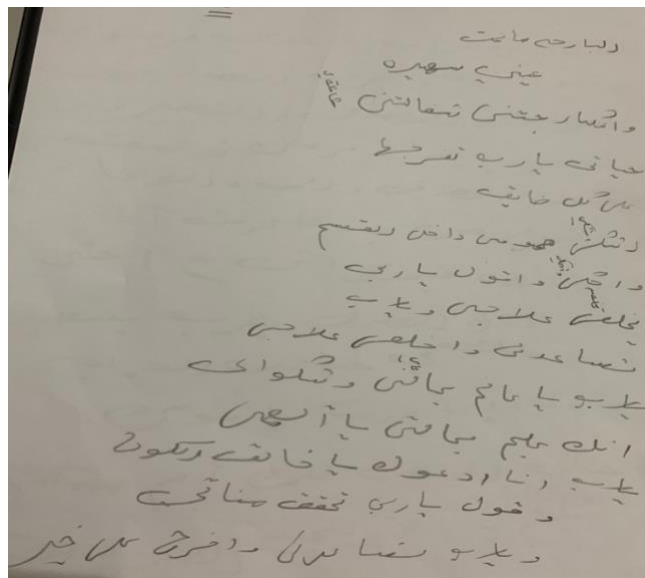


Figure 11.2: Alya's poem

Translated from Arabic to English the poem reads:

Yesterday I could not sleep
My eyes kept opening
I prayed to God to facilitate my life
And [prayed] for everyone with stress
I complained to him about my stressors in the ward
I said,
My God,
I [want to] finish [my] treatment
Help me to finish [my] treatment
My God, who knows my state and suffering:

You know my state, God.

I ask you to give me what I wish.

Help me to be happy.

Alya's poem highlights her state of sadness and sense of accumulated stressors, emphasising her wish to improve and finish her treatment. Her hope to recover and spirituality towards God are the main components of user-based recovery (Schrunk & Slade, 2007), which might identify Alya's start to recover. However, while Alya did not write anything in the poem directly about the mental health ward's services or staff, her tone suggests that she was not happy in the hospital. This tone may indicate her level of satisfaction with hospital services and care: she wrote that she was still distressed and asked God to grant her wish to complete her treatment. She might want to recover, be discharged, and return to her family and loved ones.

In addition to their experiences of mental health services, some women offered a variety of perspectives on nursing care after admission. The field notes for Hamida from Hospital A indicate that she thought the nurses were good generally, but they sometimes abused her by shouting at her, pushing, hitting her, and asking her to go away. Hamida's view indicated that some nurses' actions were perceived as abuse, shouting, and pushing consumers. This issue was discussed in greater depth in Chapter Six, but as a part of the reflective approach taken towards this research and the need to examine participants' views in this chapter, the issue will be addressed in this context. As a researcher, when I encountered this woman claiming that she was allegedly hit by nurses in the past, I was concerned; however, the woman did not display any signs of discomfort or distress at that point in the interview. Moreover, when I signed the forms at Hospital A to seek permission for data collection, no procedure regarding researchers passing on information regarding any questionable practices reported by consumers was included. KSA's Mental Health Care Law (2014) has a complaint policy and

process which enables reporting, investigating, and addressing complaints about poor practice concerning care, which reflects the fact that any consumer or any person in contact with consumers can have a say. However, the absence of such a procedure in the forms I signed before starting data collection might reflect that this procedure is not adequately activated in the hospital, and I felt that I did not have sufficient capacity to follow up this single report.

At the end of her interview, Hamida made a drawing of a car (Figure 11.3). Although I did not think that Hamida's drawing resembled a car, she said it was a car and wanted to return home, representing her hopes of being discharged. Her wish to return home might reflect her general dissatisfaction about being admitted to the hospital or be related to that practice of some nurses that she discussed. The process of admission and even the treatment in a hospital can be confusing and frightening for a consumer; however, inpatient ward staff are expected to provide support and promote recovery (Baker & Martens, 2010). For Hamida, the admission experience may have been compounded by the practice of some nurses that she reported, reinforcing her wish to go home and leave the ward environment.

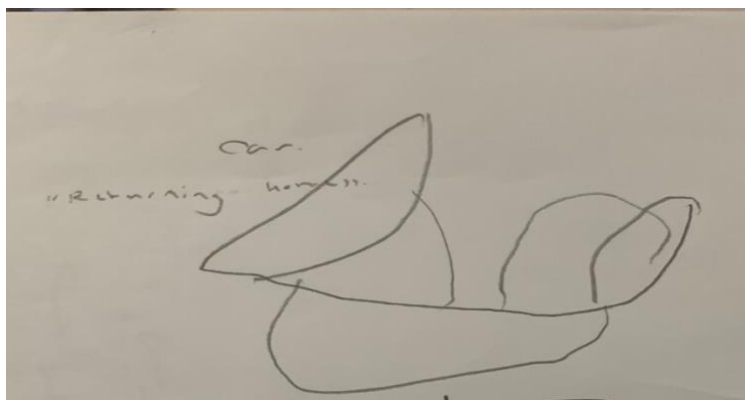


Figure 11.3: Hamida's drawing of the car

In a discussion about the nurses in Hospital B who speak a different language, Zahra said: ‘The language is a barrier between us, and there was no intimacy or ... home girl feelings, [nurses are strangers]’ (p. 13, lines 578-579). In Hospital B during data collection, I noticed that women were happy to see an Arabic-speaking person on the ward, as most nurses there were unable to speak the language fluently. This language difference was also represented as a sub-theme in the previous chapter on nurses’ perspectives; the nurses perceived this barrier of language difference through the lens of communication challenges. This language challenge adds to the mutual difficulties for both women and nurses in nursing care.

The field notes for Najat from Hospital A show that she also talked about nursing care. She said that the nurses, in general, were good with her but that the system of care at the hospital did not help her recover because she felt the staff repressed her and were not flexible. Najat illustrated this point further in her notes about her experience with the nurses’ care and services at the hospital (Figure 11.4).

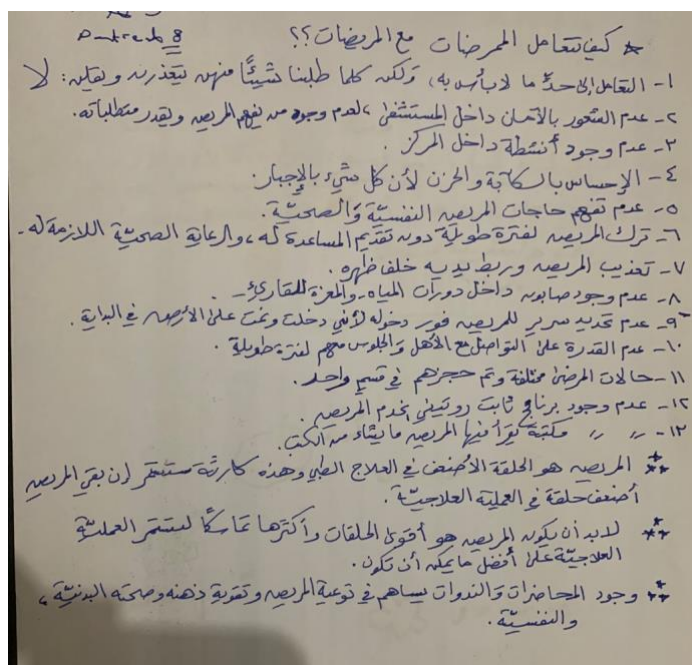


Figure 11.4: Najat’s notes entitled ‘How the Nurses Should Deal with the Consumers’

A translation of Najat's notes is offered below:

- 1- The [ways nurses deal] with consumers are not too bad, but every time we ask the nurses something, they apologise and say no.
- 2- Feelings of insecurity [are expected] in the hospital because no one [among the nurses] understands the consumers and values their needs.
- 3- [There are] no activities in the facilities.
- 4- [There is a] feeling of depression and sadness because everything is compulsory.
- 5- Lack of understanding of the consumers' emotional and physical needs.
- 6- Leaving the consumer for long periods without offering help or giving proper [mental] health care.
- 7- Punishing consumers and restraining them.
- 8- Soap in the toilets is absent.
- 9- Not allocating a bed for a consumer after admission: I slept on the floor at the beginning of my admission.
- 10- Inability [of women] to communicate with families or spend a long time with them.
- 11- The consumers with different levels [of care needs] are all in one unit.
- 12- No consistent routines for consumer care.
- 13- No library for reading.

The consumer is the weakest part of the medical treatment [at this hospital]; this is a disaster if the consumer stays the weakest part.

The consumer should [take] the most vital and cohesive part to put the treatment process into its best position.

Lectures and seminars for the consumers are needed to increase consumer's awareness and reinforce their physical and mental health.

Najat's thoughts about hospital services and nursing care offer an insightful picture of the hospital. One of her perspectives on mixing consumers with differing severities of mental illness in one unit in Hospital A resembles the situation at Hospital B, as reinforced by Joud and Karima, and again reflects the fact that there were no low-dependency and high-

dependency areas in the wards, which may cause care to be disorganised. This fact, in turn, may have caused Najat to experience additional stress during her stay.

Najat also refers to a lack of activities, lectures or information, cleanliness issues, a shortage of beds, and a lack of reading material. Lack of information and education for consumers was also indicated in nurses' views in Chapter Nine (Sub-section: *Nurses' understandings of medication adherence and relapse in psychosis*). Najat also mentioned the lack of activity, and it is known that sufficient activity in mental health wards ensures that consumers are provided with the best possible care in a therapeutic environment aimed towards recovery (South Australian Health [SAH], 2021). The use of activity in mental health wards can also help reduce boredom and aggression, allow more straightforward assessment of consumers' levels of functioning and communication and interaction with others, improve consumer satisfaction, and develop consumer skills and knowledge (SAH, 2021). Najat showed her awareness of some benefits of activity, including the facilitation of therapeutic relationships with staff. The lack of activities in the hospital may render this hospital a non-healing space for consumers. Moreover, her views about consumers' limited access to communication and contact with family, including limited visiting times, reflects the possibility that further pressure may be applied to consumers who need family support. Service-based recovery (Schrunk & Slade, 2007) is highlighted by this hospital's paternalistic and non-empowering approach to care, based on controlling their family communications, and limiting family engagement with care.

Regarding nursing care, Najat indicated that nurses failed to understand consumers, did not give consumers any choice in their care, were not present with the women, restrained women, and offered inconsistent care. These complaints show the lack of communication and therapeutic relationships, shared decision-making and empowerment, the use of restraint and

the provision of physical, non-holistic care in this facility (Schrack & Slade, 2007). These elements were also reflected in nurses' perspectives in the previous chapters, which presented the orientation of services and nursing care in mental health facilities which failed to provide these crucial elements. In Chapter Four, the nurses reported engaging in the development of therapeutic relationships with consumers with psychosis as a significant domain of nursing practice (van Dusseldorp et al., 2011); however, Najat's perspectives suggest a gap in the nurses' actual development of relationships with these women, which might negatively impact women's recovery from mental illness.

Najat also regarded restraint as a punishment. Her view can be added to Hala's view from Hospital B, who discussed her experience with the restrictive practice of seclusion: 'When I was admitted here, there was a nurse who detained us in the seclusion room, which made me get worse' (p. 1, lines 30-31). Najat framed restraining as a form of punishment, and Hala viewed seclusion as a type of detainment rather than a therapeutic practice, suggesting that it made her experience of mental illness worse. Adverse experiences of such coercive measures can cause enduring and long-term negative attitudes toward mental health institutions' care and promote trauma (Steinert et al., 2007). Such experiences can also trigger existing trauma histories (Hammer, Springer, Beck, Menditto, & Coleman, 2011). The negative impact of seclusion was reflected by Hala's conclusion that seclusion made illness worse, which might be linked to the trauma represented by Najat's view of restraints as punishment.

This sub-theme of KSA women's experiences with mental health services and nursing care after admission emerges as a rich topic, with different perspectives from both hospitals. The women's experiences included their perspectives, feelings, and attitudes towards mental health services and nursing care, and their relationships with nurses and other individuals in mental health facilities were investigated using van Manen's (2014) existentials. Three texts:

a drawing by Halima and two writings of other women, were explored using van Manen's (2014) vocative analysis method to unveil the meaning in these texts earlier in the pre-analysis stage. It is worthwhile developing recommendations based upon the experience of women with psychosis to help them receive better mental health services and nursing care to assist their recovery. Some of the women's comments illustrate the following recommendations.

Regarding improving mental health services, Joud commented: 'They [mental health services] should separate the serious cases away from stable or new ones' (p. 3, line 100). This view highlights a consumer's issues with the current style of mental health wards allocate all consumers to the same units regardless of level of acuity. More clearly defined allocation of space could help women recover from psychosis.

Najat's notes about mental health services suggest two further points that may improve mental health services. The first is consumer's involvement in their treatment plans where possible, which would empower consumers by offering them a proactive role in their treatment plans. The other recommendation was the need for educational activities in the facility, which she viewed as an essential part of consumer services: 'The consumer should [take] the strongest and most cohesive part to put the treatment process into its best position. Lectures and seminars for the consumers are needed to increase consumer's awareness and reinforce their physical and mental health'.

Najat commented on feeling insecure in the hospital, highlighting that the nurses did not understand their consumers or value their needs. Zahra discussed how nurses could address consumer needs by offering advocacy and support based on mental healthcare policy to decrease consumer's misunderstandings:

I hope that the nurse stands with the consumers and tells them about the policy and rules whenever a consumer [is hospitalised]; even if they are psychotic consumers, they will realise what you say because they have some awareness. The nurse should say, ‘This is a hospital, not a home, the system of sleeping, eating, and watching TV [is...] and you have to ask the responsible doctor [about your situation] only’; I found this [to be an issue] the first time I went to the hospital. I did not know that one psychiatrist took responsibility and others did not, or that a doctor had my file and other [staff] might not know anything about my case. They thought that I was asking the other doctor [inappropriate questions] because of my psychosis, while the fact is that I did not understand the system. I was young, and it was my first time in hospital, and I did not know anything about the system. They were supposed to explain to me that ‘this doctor is responsible for your case, so do not ask [the other] doctor. This nurse is responsible for your case, so do not ask [the other] nurse. Whenever you need anything, ask those responsible for your case. If you are bothered by something, tell [such-and-such] a nurse in detail’. (p. 12, lines 545-557)

Zahra’s recommendation for nurses to advocate for women to ensure they know the facility’s policy after admission is an addition to how women can experience better care if they understand the system. Regarding restrictive practices by nurses, Hala and Najat saw nurses’ secluding and restraining women as punishment and made their illness worse. These practices can be addressed by decreasing seclusion and restraint by implementing widespread restraint reduction initiatives, such as enhanced nurse training in conflict de-escalation techniques and focusing on person-centred care (Jacob et al., 2016; Muir-Cochrane et al., 2018). Replacing harsh restrictions with alternatives might also help, mainly where chemical restraint is possible (Muir-Cochrane et al., 2018). Muir-Cochrane et al. (2018) also recommend additional support from the management of each facility to create a change in the ward culture to the reduction of restrictions by developing new methods, procedures, and practices, such as moving consumers who show a risk to themselves or others into another environment. The use of trauma-informed care in acute inpatient wards is also recommended (Hall et al., 2016), and this can be applied through the provision of educational and training packages in facilities to reduce the practice of restriction (Muir-Cochrane et al., 2018). If

used for consumers like Hala and Najat, such methods might decrease the sense of punishment and support recovery from psychosis.

From women's perspectives, this user-based recovery approach (Schrang & Slade, 2007) means empowerment and shared-decision making, receiving holistic care and decreased use of restrictive practices that represent physical care only, and advocacy for women. The women were aware of their needs to recover, which mental health facilities should address.

Following the exploration of KSA women's *experiences with services and nursing care* after admission, the last sub-theme explores the women's need for healing space.

11.3.4 Sub-theme 4: The need for a healing space

After admission, women's spatial healing experiences were understood through the lived space lifeworld existential of van Manen (2014). The aspects of place and space that may mediate health are well established (Bell et al., 2018), and the importance of hospital spaces for treatment outcomes and the general wellbeing of consumers (Lawson et al., 2002) is also well established. For mental health specifically, healing spaces were identified by features and aspects of the built physical environment. Examples include lighting and ambience, the colour and quality of materials used, food quality, air conditioning, access to views overlooking green spaces, accessibility, and openness, all of which can have a positive impact on consumer experiences and their wellbeing and recovery (Curtis et al., 2007; Reavey et al., 2017). A mental hospital should create a homelike atmosphere for consumers with features such as lighting and soft furnishings to enhance a supportive environment for healing (Waller & Finn, 2004). Curtis et al. (2007) recognised the importance of the homeliness of mental health spaces where consumers can perceive being in a relaxed, warm atmosphere more in tune with healthy day-to-day living. The sense of security among consumers also makes mental health facilities more homely and less institutional and is

considered essential to promoting recovery (Curtis et al., 2007). Such aspects suggest that mental health hospital spaces are essential to consumer wellbeing due to their bearing on perceived levels of respect and empowerment among people with mental illness, the benefits of psychological comforts offered by homely environments, and the healing properties of contact with nature (Curtis et al., 2007).

Based on the perspectives of the women in this the present study, the impact of mental health hospital space is a significant factor in their experience of psychosis. Many women emphasised a need for gardens and open spaces, as Safiya stated: ‘I wish they would provide gardens [or] free us to get to the garden of the hospitals. Norah: Talk to me more about this need. Safiya: We need to get fresh air and oxygen’ (p. 2, lines 70-73).

Nahla similarly said ‘we need a park’ (p. 2, line 56), while Zahra said:

Going for a walk and some air is essential. I know the mental health department is beside a garden, [but] they do not let us go to the garden as it takes time to bring all of us together, and problems might occur. (p. 13, 609-611)

Joud also stated

I did not see the sunlight; I felt that I was locked in a box. We need to spend time in the gardens, or at least [to] have a window in the room to see the sunlight. The day was the same as [the] night; the only difference was the light. The place is depressing, and it should be [made more] suitable for mental health consumers. (p. 3, lines 68-71)

These views suggest that the environment of the wards is not helping to heal, mainly due to the lack of access to gardens or fresh air. It is sometimes argued that spaces must encourage contact with nature to support mental health (Curtis et al., 2007). Incorporating natural elements such as plants, water features, and views of natural scenes in mental health hospitals is often invoked as being therapeutic and improving health outcomes (Parr, Philo, & Burns, 2003). Exposure to green space is imperative in such facilities; this exposure improves

mental health (van den Berg et al., 2015) and decreases the risk of psychosis (Engemann et al., 2018).

Jana commented that the lack of a garden made the women feel like prisoners:

It would be better for the ward to have a garden: under the monitoring of the staff...it would be more effective for the consumers to see the trees: [this is] what makes the treatment more effective. It is a bad feeling for a woman to feel she is imprisoned. (p. 3, lines 94-97)

Jana views reflect an impression of the ward as a jail-like environment. As Curtis et al.

(2007) highlighted, as consumers try to recover from mental illness, they do not want to feel that they are in jail. This feeling might also be compounded by visitors if the family and friends who visit the consumers think the ward is jail-like (Curtis et al., 2007). This perspective is supported by Jana's feeling that she was in jail rather than in a place where she might recover from psychosis.

Zahra raised other points relating to the ward environment, including the limited cleanliness and sanitation:

Cleaning and caring for the building are essential points.... I remember they put the food on the bedsheets...which the consumers slept on. They used the same floor mop in sweeping both the floors and bathrooms the mental health ward...smelled terrible. (p. 13, lines 586-591)

Zahra mentioned practices that represented limited cleanliness in the mental health ward, reflecting the lack of healing space. Several reports on mental health hospitals' cleanliness have shown that they have worse sanitisation standards than other specialties in the same hospitals (Department of Health, 2005). However, it is believed that clean, tidy, and neat mental health buildings reflect a positive, respectful attitude by people outside the building towards consumers with mental illnesses (Curtis et al., 2007). Therefore, it is essential to pay attention to the consumers' views such as Zahra to address the need for better sanitation in mental health wards to make these spaces better places for healing.

Zahra also discussed the problem of not having a kitchen accessible to consumers to allow them to obtain beverages or to store and eat their food as they wished:

There was a dining room, which we went to [for] lunch and dinner. However, at ... breakfast, they did not allow us to go there and told us to eat quickly on the couch.... They [nurses] took the oranges that were left by the consumers and [the] spoons. It was impossible to [get another] spoon for food.... They put piles of oranges in the refrigerator, and when you asked them for one, they gave you [it, only grudgingly]. The remaining milk was put in the refrigerator, and when we asked for it, they [seemed to consider] it a favour. Even when we asked for cold water in the summer, they considered it a favour, and when they gave us a bottle, they said 'write your name on it and put it in the refrigerator'. When my husband brought me cold bottles of water, they, after my suffering thirst, agreed to put it in the refrigerator for use the next day.... I would hope there would be a room for the consumers, like the nurse's room, containing water, juice, a microwave, or a room where sandwiches and fruits were always available. (p. 13, lines 592-607)

The researcher observed that in this inpatient ward in Hospital B, the nurse's station contained a door leading to the treatment room. There was a small fridge in the treatment room, where water and cold drinks were stored for the women; however, the fridge was only accessible by nurses. Zahra's views reflect the need for facilities which fulfil basic human needs and provide access to drinks and food. Zahra's other point was that if a woman required a drink, she first had to ask the nurses to bring her a drink from the fridge. It is important to note that these women were prescribed psychotropic drugs, and some were taking antipsychotics, which cause side effects, including a dry mouth. Access to water is vital to alleviate this particular side effect (Hashimoto et al., 2012). This issue might be the other reason why Zahra requested that women need to have a kitchen with a fridge.

A mental health space should offer a sense of homeliness to enable the individuals in it to develop a sense of attachment to the building (Curtis et al., 2007). This sense is sometimes referred to as *topophilia*, defined as emotional attachment to a place (Parr et al., 2003).

Zahra's opinion about having a kitchen in the ward reflects her need to feel attached to the

place and experience it as a homelike space where she could access its facilities without needing to seek permission.

The need for a healing space sub-theme illustrates an aspect of their experiences with psychosis after admission, and their experiences of psychosis and recovery in relation to the spatial aspect of the mental health facility as a healing space were explored using van Manen's (2014) lived space lifeworld existential. The interviewees identified their needs and made recommendations to make the mental health facilities healing spaces: the need for greenery, cleanliness and sanitation, and access to a kitchen. Therefore, the design of KSA mental health facilities should include the healing elements that consumers need as reflected in this sub-theme. Moreover, rather than relying on designers alone when planning mental health spaces, it is recommended that consumers be involved in offering as much input as possible into the organisation and planning of their own spaces (Curtis et al., 2007).

Examples are assigning rooms to various activities, such as Zahra's suggestion of having a kitchen, or choosing wall colours and curtain fabrics (Curtis et al., 2007). Involving consumers in design could make mental health facility spaces conducive to healing from mental illness.

Overall, the theme reflecting the experiences of KSA women with psychosis after admission or follow-up is rich, and four sub-themes emerged. These experiences were analysed using van Manen's (2014) lifeworld existentials. In the *admission or follow up experiences* subtheme, the interviewees reported their feelings, thoughts, and relatedness with others about follow-up or admission. Some ideas of persecution through being watched on CCTV were mentioned. The sub-theme of *experiencing psychotic symptoms and insight into psychosis after admission* explored their understandings of psychotic symptoms, accompanied by various levels of insight into psychosis. Study participants discussed living

with TV in the hall and CCTV in the bedroom, and their experiences of this technology affected their experience of psychosis. The third sub-theme *experiences with services and nursing care* reflected women's views of the services both experienced and omitted in both hospitals, and their views about issues related to nursing care. Their feelings, attitudes, responses, and relationships were also shown concerning services and nursing care.

Their views revealed their need for a user-based rather than the current service-based approach to recovery from mental illness (Schrang & Slade, 2007). The user-based approach needs to include empowerment and shared decision-making, involve information and education, engagement with family in communication and care, be holistic rather than only physical care with restrictive practices and advocate treatment (Schrang & Slade, 2007). The last sub-theme was built on the women's spatial experiences of mental health facilities, reflecting *the need for a healing space*. This theme emerged from the recommendations of interviewees which reflected their need for ward spaces which provided access to nature and were clean and homely.

The following final theme explores the experiences of interviewees after discharge and how they experience community life after receiving treatment in a mental health facility.

11.4 Theme 3: KSA women's experiences of living with psychosis in the community after discharge from a mental health facility

The women's views on living with psychosis after discharge were understood using van Manen's (2014) three lifeworld existentials to build the theme: lived body, lived self-other, and lived cyborg. A discussion of how these existentials were used is provided in the following sub-sections. A drawing of a woman was also analysed with the support of van

Manen's (2014) vocative analysis method to uncover the meaning of this drawing before beginning the interpretation of the text.

The sub-themes which emerged in this theme were: 1). *experience of medication adherence*; 2). *living with family, friends, and the community*; 3). *recovery from psychotic symptoms and developing insight into illness*; and 4). *experiencing recovery in terms of education, employment, and religion*. These sub-themes of the women's experiences of psychosis after discharge from mental health facilities are represented in Table 11.3.

Table 11.3: Sub-themes of the theme of experiences of KSA women with psychosis after discharge

KSA Women's Experiences of Living with Psychosis in the Community After Discharge from a Mental Health Facility	
Sub-theme 1	Experience of medication adherence.
Sub-theme 2	Living with family, friends, and the community.
Sub-theme 3	Recovery from psychotic symptoms and developing insight into the illness.
Sub-theme 4	Experiencing recovery in terms of education, employment, and religion.

The lives of women with psychosis discharged from mental health facilities were examined by Galderisi, Bucci, Ukok, and Peuskens (2012), who indicated that it is not uncommon for women to return to work or marry and bear children. Women often also continue to maintain their friendships and affiliations with their families and most commonly adhere to their prescribed medication regimens (Galderisi et al., 2012). However, in KSA, no previous research has explored aspects of KSA women's recovery from psychosis after discharge. The women's views explored in this theme may add some insights into their lived experiences of psychosis at this stage of recovery.

11.4.1 Sub-theme 1: Experience of medication adherence

The experiences of the interviewees, including their development of an understanding of the importance of adherence to medication, were analysed based on van Manen's (2014) lived body perspective. The impact of their relationships with others, including staff and family, on

adherence to medication regimes were investigated using van Manen's (2014) lived self-other.

Psychotropic medications, particularly antipsychotics, are the cornerstone approach applied to treating and managing people with psychosis (Bülow, Andersson, Denhov, & Topor, 2016; Hui et al., 2016), and symptom management through medication is a central component of the user-based approach to recovery (Schrang & Slade, 2007). A primary concern with such treatment is consumers' adherence to their antipsychotic medication regimens, as adherence has been shown to prevent relapses, thereby favourably influencing outcomes (Bonsack, Favrod, & Morandi, 2017). Non-adherence to medication, in contrast, is highlighted by Caseiro et al. (2012) as one of the strongest predictors of symptomatic relapse in consumers with psychosis.

Many women interviewed in this research had clear views about medication as part of their experience of recovery from psychosis. For example, the field notes of the interview with Hamida indicated that she was aware of the importance of adherence to medication in her recovery from psychosis. She considered adherence to be a significant enabler of recovery, promoting her development of a stable situation. However, she noted that if she was starting to relapse and developed acute symptoms, she could not perceive reality and was inclined to stop taking her medication.

Hamida indicated that relapses occurred when she failed to take medication to relieve symptoms. Increased severity of positive symptoms, which are seen as acute symptoms, is often a predictor of medication non-adherence (Sendt, Tracy, & Bhattacharyya, 2015). This may explain Hamida's tendency to discontinue taking her medication at such times, and at the time of the interview, she showed awareness about this link between experiencing relapse and ceasing her medications.

Some women did not see the need for medication after discharge; these women believed that the medication did not facilitate their recovery. According to field notes of her interview, Halima viewed medications as useless, and felt she did not need them because she no longer had any illness. The field notes on Eliana's interview also included her mentioning that medications do not help her to recover.

Halima's and Eliana's views suggest that they may discontinue taking medication after discharge. Similar discontinuation is well reported in the literature, based on several clinical antipsychotic trials, with 74% of consumers with psychosis in one study discontinuing their prescribed antipsychotic treatment (Lieberman et al., 2005). In another study, it is estimated that 60% of all medications are taken incorrectly or not at all by consumers with psychosis (Hardeman, Harding, & Narasimhan, 2010).

In addition to her claim that medications were useless, Halima added that she did not regard herself as a woman with mental illness, reflecting a lack of insight into psychosis. Lack of insight into psychosis is identified as a predictor of medication non-adherence (Sendt et al., 2015). Bülow et al. (2016) found that some consumers with psychosis did not believe they needed to take medication, believing instead that they were forced to take them by others. In contrast, insight into psychosis, including knowledge of its consequences, has been associated with therapeutic adherence by consumers (Goff, Hill, & Freudenreich, 2011).

Halima's sense of the medication being useless suggests a lack of insight into psychosis.

Zahra discussed her experience of side effects from medication after discharge. Her psychiatrist worked with her family to help her to adhere to her medication regimen despite these side effects:

When I took Clopixon [antipsychotic] for the first time, its side effects were so harmful. However, the doctor asked my father to understand that I should endure these side effects. This [would offer] great benefits in

treating my psychotic thoughts. I trembled and had spasms, which affected my lips and changed their shape, [along with] vomiting. If I felt those side effects [worsen], I was to go to the doctor immediately. (p. 10, lines 460-464)

Zahra's experience of adherence to taking a particular antipsychotic was linked to an understanding of its side effects. The efforts of her psychiatrist to recruit her father's help in encouraging her to tolerate these side effects to aid recovery had an impact. However, Zahra did not indicate of being engaged with the physician and her father to negotiate her choice or give permission to take antipsychotics. This issue may relate to the dominance of the service-based recovery approach (Schrank & Slade, 2007) with her physician, by which the consumer should obey the provider's orders without having any choice of treatment. Regardless of this gap in the service, Zahra's physician's advice to her father about the medication's side effects helped her adherence. Most side effects Zahra reported related to her appearance, including trembling and spasms affecting the shape of her lips. Seeman (2011) suggested that women's concerns about their appearance and outward attractiveness may add emotional challenges for women with long-term exposure to antipsychotic drugs due to multiple side effects, as appearance is generally seen as more important to women than men (Seeman, 2011). Examples of side effects are weight gain, greasy skin, acne, loss of hair, shuffling gait, tremors, loss of teeth, and dyskinesia. These changes in appearance might discourage women from adhering to medication. Additional support is given to Zahra by her father regarding understanding the side effects and the importance of adhering to the medication schedule to facilitate recovery might have overcome her concerns about her side effects.

The perspectives of interviewees on medication adherence after discharge from the hospital into the community reflect that medication is a significant part of women's experiences after discharge. Their reported experiences highlighted the importance of and need for medication adherence and the influence of staff and family on reinforcing medication adherence and

tolerating side effects; these experiences were investigated using van Manen (2014) existentials.

As part of developing an understanding of consumers, it is worth recommending education to improve medication adherence. As illustrated by Zahra's situation, one strategy of education includes the provision of education by psychiatrists to help consumers' families understand the possible side effects and the importance of enduring these effects to maintain and promote recovery. Furthermore, social support, including that from family, as represented by Zahra's father's inclusion in her treatment meetings has been identified as an essential factor fostering medication adherence in consumers with psychosis (Quach et al., 2009).

In relation to educating consumers, Hui et al. (2016) suggested that professionals should pay additional attention to consumers who appear to be at higher risk of non-adherence and provide relevant assistance before discharge. This attention might include more targeted education and frequent reminders about medication intake for consumers with more severe psychotic symptoms (Hui et al., 2016). After discharge, consumers need appropriate educational programs on adherence problems related to psychosis, which may be a helpful way for mental health facilities to support their consumers in the community (Hui et al., 2016). Engagement with and educating family and consumers about how to help consumers manage symptoms of medications is a major element of the user-based recovery approach (Schrack & Slade, 2007), which needs to be considered by mental health facilities.

Another sub-theme emerging from the experiences of interviewees after discharge is *living with family, friends, and the community*.

11.4.2 Sub-theme 2: Living with family, friends, and the community

Interviewees' experiences of relatedness with family, friends, and others in the community after discharge from facilities were interpreted using the lived self-other of van Manen

(2014). Their thoughts and feelings about their relatedness to others after discharge were interpreted by the lived body lifeworld existential (van Manen, 2014). A drawing by a woman was also analysed with the support of van Manen's (2014) vocative analysis method. Overcoming stigma and becoming empowered and supported by family and community have been described as components of user-based recovery (Schrack & Slade, 2007). The literature review in Chapter Three (Alyahya et al., 2022) suggested that consumers experiencing psychosis generally struggle with their social relationships with the community. One study in the literature review, that of Nxumalo Ngubane et al. (2019) reported that women with psychosis tend to feel that their families and communities often take a paternalistic stance based on knowing what is best for women and intervening accordingly. Such relationship patterns are painful, and the women indicated that they were ignored, rejected, not listened to, or understood, and further segregated by society (Nxumalo Ngubane et al., 2019). In another study, Jenkins and Carpenter-Song (2009) identified family, acquaintances, and friendships as being impacted negatively by stigma, while Walsh et al. (2016) stressed the influence of stigma following diagnosis and symptoms of psychosis on consumers with psychosis, suggesting that this leads to alienation from families, friends, and communities.

In the present study, the roles of family, friends, and the community in recovery after discharge were highlighted by interviewees from various perspectives. Some women discussed the fact that their families were not supportive after discharge. The field notes on Hamida show that she indicated that her family, including her husband and her daughters, were not supportive. They hit her and were sarcastic to her. She said, 'My daughters told me 'You are crazy; you are like a child'', while her husband told her when she asked him to take her to hospital, 'You are okay, you do not have an illness'.

Lama also discussed her family not supporting her recovery: ‘My siblings do not talk to me, which made me disturbed and upset. My father told them to treat me the hard way. In other words, my family does not support [my recovery]’ (p. 1, lines 37-38). The field notes on Alya record that she acknowledged that her children supported her, but that other family members, such as her husband, daughters-in-law, and other relatives, did not. Her husband and relatives called her a ‘crazy woman’, which aggravated her situation; she said, ‘I hated the crazy word’.

How Hamida, Alya, and Lama discussed their families indicated that their families were not supportive of their recovery from psychosis after discharge. There was also a presence of domestic violence among these families. With Hamida, this took the form of her family being sarcastic about psychotic symptoms and hitting her. Hamida and Alya also noted that their families labelled her as ‘crazy’, and Lama indicated that her family refused to communicate with her. Previous research has found that many women with psychosis experience domestic violence, which may take the form of both emotional and physical abuse (Howard, Trevillion, & Agnew-Davies, 2010); for the women in the present research, domestic violence compromised their recovery from psychosis. These responses of women also highlight the presence of stigma based on the families’ reactions. The stigma and prejudice associated with psychosis are worse than those associated with any other mental illness (Pescosolido et al., 2010), and to experience this stigma among their families left these women feeling unsupported.

Emotional abuse was also reported by Jumana, who illustrated her thoughts and feelings about her husband by creating a drawing of a broken heart, as shown in Figure 11.5.

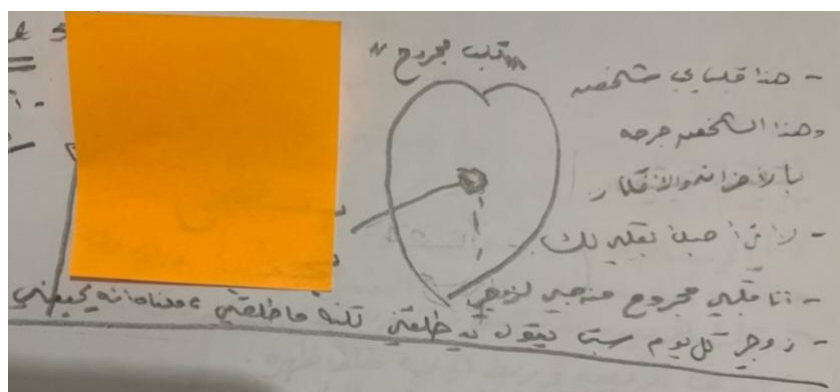


Figure 11.5: Jumana’s drawing, entitled ‘Broken heart’ (The identification of this woman has been concealed)

Jumana described the drawing and discussed its reference to her husband:

- It is a broken heart...it is a heart that loves someone, and this one [her husband] hurt this heart, with sadness and overthinking.
- Because I love you [her husband], my heart will be for you.
- My heart got hurt because of my love for my husband.
- My husband, every Saturday, says he will divorce me, but he did not, which means he still loves me.

Jumana’s drawing and comments reveal that her husband hurt her, compounded by her husband continuously threatening her with divorce while maintaining the marriage. This issue created confusion for Jumana and reflects a particular form of coercive and manipulative control often used by intimate partners against women with mental illness (Islam, Jahan, & Hossain, 2018). Women with chronic mental illnesses such as psychosis face multiple forms of physical, verbal, social, or sexual violence (Islam et al., 2018). The explanation for this violence offered by Islam et al. (2018) is that when these women undertake eccentric activities which exceed social limits, their partners use this as an excuse for violence, claiming this to be a consequence of unacceptable behaviour, irrespective of their partner’s social class and creed or any understanding of mental illness. A partner’s intolerance of mental illness should not be taken as an excuse for the abuse reported by

Jumana, however, and it may well obstruct recovery, as many psychotic symptoms are provoked by insecure attachments and trust issues (Lavin, Bucci, Varese, & Berry, 2020).

Abuse by a partner is, therefore, likely to exacerbate such illness, and the consumer may be unable to recover while such emotional hurt is ongoing (Islam et al., 2018), as is the case with Jumana's statement that her husband regularly threatened divorce.

Families may also impede recovery from psychosis based on their misunderstandings of recovery. For example, Nadia mentioned that her family did not support her when she was seriously sick, as they felt she could not recover. She said,

My family was putting pressure [on] and disturbing me, and [I experienced a] serious relapse. In the beginning, I thought I would never be recovered because I was sick.... I was aware of my case and how I was sick and needed to recover...I recovered because I continued the treatment, and I improved the way I dealt with my family. Consequently, I enjoyed [better] communication skills. When I was sick, no one [in the family] helped me; they thought I would never be recovered. They did not support me, but I supported myself [by accepting] treatment. (p. 1, lines 34-44)

Abeer discussed the confusion she experienced when her family prevented her from finding out what she needed to know about psychosis, which seemed to reflect their lack of understanding about psychosis and recovery:

I wondered what was wrong with me, and no one told me. The family was afraid of my reaction: they feared that I would be shocked and disturbed. When I read the leaflet [about medication], my aunt cut it into pieces and told me I should not read such leaflets because they delude you with things you are not. I know that she said [this] because she loves me, she did not mean to hurt me, but it was not the right decision. When I could understand the treatment methods, I could understand myself more, which will facilitate the process of treatment and recovery. (p. 2, lines 72-78)

Nadia and Abeer felt the effects of family misunderstanding of illness and treatment, which often cause distress to those with psychosis. A family's limited knowledge about mental illness and the associated symptoms may hinder a consumer's recovery from psychosis (Hasan & Musleh, 2017). Family misunderstandings of illness in Nadia's situation reflected their belief that there was no hope she would recover, causing them to lack motivation to

support her treatment. Limited family knowledge of mental illness also affects family beliefs about mental illness (Cadario et al., 2012). Nadia's family's belief that there was no hope of recovery led to a negative response regarding withdrawal of help (Connor et al., 2016), showing how the lack of family knowledge may undermine recovery. Family resistance to treatment might also be attributable to fear of stigma and prejudice in the community towards a family who has an individual with mental illness (Martin et al., 2018), which may be another reason for Nadia's family's withdrawal of help. In Abeer's family, misattribution of symptoms was represented by the family's belief that if she had any knowledge about the illness, it might exacerbate it. Family members' misattribution of psychotic symptoms may also be explained by a lack of knowledge about psychosis and its presentation (Oluwoye, Cheng, Fraser, Stokes, & McDonell, 2020). Both Nadia's and Abeer's families' limited knowledge negatively affected them in different ways while they tried to recover.

Zahra illustrated how her friend's misleading ideas about recovery caused her to neglect her medication regimen; after she stopped taking the medication, she relapsed:

One woman caused me significant problems, as she told me, 'Marriage will solve the mental problems...one of the [consumers] was mentally ill, and when she married, she was recovered'. Once I adopted this idea, I neglected my medications, took [only] 2 mg, hardly [any], and did not take it daily. I thought that [if] I got married and recovered, I would not need the medication anymore. I thought that marriage and stability would solve my problem.... After I stopped taking the medication, I relapsed slightly. (p. 9, lines 431-438)

Zahra's friend's advice indicated that some people in the community had limited understanding of recovery from psychosis. Consumers with psychosis may experience or perceive a lack of understanding of illness from multiple community networks (Sale et al., 2018). This limited understanding by Zahra's friend about recovery on marriage caused her to mislead Zahra, who suffered a relapse due to non-adherence to her medication.

Karima's experience with psychosis in the community was expressed in terms of the story of her previous marriage and the proposals she received from men who were then made aware that she had psychosis:

In my first marriage, I did not let my husband know about my illness. But after one week, he knew about it, which caused trouble between us, and we got divorced.... Each one [who has] proposed to me and [was told] about my condition withdrew. I do not blame them, as they did not know [much about] the nature of my illness. When they ask [my family] about my condition, they are told that it is stable, but they do not know that sometimes I [am] stable and some other [times] it gets worse. (p. 4, lines 164-170)

This view reflects how mental illness in the family is viewed as a shameful secret that should not be exposed to a potential husband. Karima's report highlights the effect of social stigma of psychosis on women's marriage prospects. Although international research shows that women with psychosis are more likely to marry and look after children than men with psychosis (Abel, Drake, & Goldstein, 2010), Al-Krenawi et al. (2009) found that, in Middle Eastern communities, women with mental illness are usually more vulnerable to social stigma than men. Mental illness can harm a woman's marriage prospects or prompt her husband to take a second wife (Al-Krenawi et al., 2009). Karima's experience confirms that her chances of marriage were reduced once potential suitors knew about her mental illness. Her previous marriage ended in divorce for the same reason.

Overall, the sub-theme of *living with family, friends, and the community* after discharge is rich in women's perspectives. The women's relationships, thoughts and feelings linked to relationships with others after discharge and how these experiences impacted their recovery from psychosis were explored using van Manen's (2014) existentials. A drawing was also analysed with the support of van Manen's (2014) vocative analysis method through exploring the broken heart drawing of Jumana's that reflects her experience of the relationship with her husband.

Many interviewees' reports of their interactions with family, friends, and others in the community after discharge reflected their experience of domestic violence, stigma, misunderstanding, and rejection by partners or potential partners. These experiences call for the identification of ways to enhance women's recovery after discharge. Jana's perspective on her lack of communication with her family after discharge reflects this concern:

'Regarding the communication service with the family, they [mental health professionals] continued communicating with the family throughout my stay at the hospital [but] they stopped when I was discharged' (p. 3, lines 103-104). It is essential that mental health facilities continue following up with consumers after discharge to check that family support is in place to promote their recovery. The women with psychosis studied by Nxumalo Ngubane et al. (2019) revealed that regular support from their families, both emotional and financial, was essential for their recovery; this support also increased their motivation to overcome illness. Education for family and community to increase awareness of psychosis might help combat community misunderstandings of psychosis and recovery. Members of the community, especially family, need to support consumers and understand that user-based recovery from mental illness does not necessarily refer to a complete cure for the illness but rather to living with the illness and functioning to the best of one's abilities (Schrang & Slade, 2007).

KSA women's recovery from and insights into psychotic symptoms after discharge are the third sub-theme.

11.4.3 Subtheme 3: Recovery from psychotic symptoms and developing insight into illness

The women's experiences of recovering from psychotic symptoms and their awareness of their illness including relapse prevention and warning signs of relapse, were understood

through the lived body existential. These experiences, which also impacted women's relationships with others, including mental health professionals, family, and community after discharge, were analysed using the lived self-other existential. In addition, the influence of technology, represented by media platforms such as the internet and TV, impacted psychotic experience and recovery, which was investigated using the lived cyborg existential (van Manen, 2014).

As stated previously, insight into mental illness is an element of user-based recovery (Schrack & Slade, 2007). The importance of developing understanding and awareness of psychosis for living in the broader community after discharge is supported by Tastet, Verdoux, Bouisson, Destailats, and Prouteau (2014), who suggest that better insight into psychosis predicts higher levels of community function and social contact. In this sub-theme, several women told stories about their experiences following hospital discharge, and more specifically, how their understanding of psychotic symptoms affected their success in living and functioning in the community. They also illustrated how they had helped themselves to recover from specific symptoms while preventing or recognising relapse.

Zahra affirmed that when she tried to read more about psychosis, she became confused; she decided to not acquire more information as a mechanism of her recovery experience:

I do not read about [my] illness on the internet, books or anywhere. [Previously], when the doctor said that I was a reader and well educated, I said to myself: 'I should read [up and become] well educated about this matter'. [However], when I tried to read [about it], I felt lost, so I decided not to read anymore to protect myself. I already have a good knowledge that makes me able to communicate with doctors, so I [do] not [seek out more] details to confuse my thoughts. (p. 8, lines 365-370)

Zahra discussed her preferred mechanism for protection from confusion, which was to not look too deeply into the available information on psychosis. Developing illness management strategies is an aspect of user-based recovery (Schrack & Slade, 2007), and this was a simple

strategy for Zahra. The reason for her decision was that she did not want activities that required mental energy, such as reading about psychosis:

One of the most essential points that helped me to recover: I did not like the internet or watching TV programs, and I did not read newspapers, books, or magazines. I did not take anything seriously and did not think of anything. What affected my brain severely and made me tired was studying. It ... made me worse... I liked cooking, playing with children every day, helping them wear [their clothes] and talking with my husband. I did not take anything seriously, and that helped me so much. I spent my time in simple things and, I liked things that did not take great mental energy. (p. 10, lines 465-471)

Zahra's view also reflected that some media platforms, including the internet and TV, if used, might impact her recovery. This view might represent that technology use may impact the experience of psychosis and recovery.

For Jana, her recovery from delusions was based on following her psychiatrist's educational tips: 'I followed the doctor's directions: for example, the doctor in charge of me in [my] last relapse taught me how to deal with my delusions of magic although I was so ill, and I used his educational tips later' (p. 1, lines 39-43). Jana indicated that her recovery began after following her psychiatrist's tips on dealing with delusions. While she did not reveal these tips, she utilised the tips by controlling delusional thoughts after her initial recovery.

Information and education for consumers, a factor in user-based recovery (Schrang & Slade, 2007), helped Jana recover. Bossema et al. (2011) similarly assert that education for consumers is an essential and auspicious element of non-pharmacologic treatment for psychotic illness, which results in them gaining more knowledge which enables them to cope with illness more effectively. In her situation, knowledge about handling delusions helped Jana to recover.

Abeer described her method of recovery as being based on accepting having an illness:

At the recovery stage... I had some thoughts [delusions], but I realised that they resulted from the illness, so I ignored them because being afraid of

illness is an illness. I do not want to worsen my illness [so] I am honest with myself... I did know [at that time] that I was on the course of recovery.

The first thing that helped me in my recovery was when I knew what I suffered from when I read that I suffered from schizophrenia. I was shocked, but over time I thanked God that I was not the one acting this way but the illness. It was not me repeatedly thinking [these things], but the illness. I am an ordinary person: someone [telling] me that what I am suffering from is an illness helped me a lot. (p. 2, lines 61-71)

Abeer's perceptions and understanding of delusions and psychosis aided her recovery by accepting her experience of psychosis. Her newfound insight into psychosis facilitated this acceptance and helped her to recover. Recognising and accepting an illness is an element of user-based recovery (Schrang & Slade, 2007). Walsh et al. (2016) examine the meaning of recovery from psychosis from consumers' perspectives, noting that the process of acceptance of illness is related to regaining a sense of self and facilitating re-engagement with life. This acceptance is reflected in Abeer's experience, with her re-engaging and regaining her sense of self by being honest that delusions were part of illness, which helped her control the influence of the delusions and psychosis.

Karima noted that she had not relapsed for the past ten years, which she attributed to not missing appointments, allowing her to remain continuously insightful about illness. She also considered that medication adherence and self-reliance accounted for her steady recovery:

I kept [up with my] follow-ups to consult with my doctors and learn more about my case. The doctors said I am aware of my case: when a doctor prescribed Tegretol for me and I said it is used to treat seizures, he liked that I had that knowledge. What helps me is my awareness of my case. I keep up [with my] follow ups and never skip any of them. Doctors used to be impressed that I [kept] up with the follow ups. All [of the] doctors agreed ... that [illness I have] is a chronic condition and needs regular treatment, the same as treatment for high blood pressure or diabetes. I must continue the course of treatment forever, and if I stop it, I will get relapses...I could stop taking Depakine [for mood symptoms] but never Zyprexa [for psychotic symptoms] because I realise the difference between my medications. They said that the voices I heard occurred because of hallucinations, [but that] consumers must depend on [themselves] to recover. I thank God, and I am also proud of myself, [my] efforts and patience that helped me overcome this illness. (p. 5, lines 203-213)

Karima highlights the impact of keeping appointments with psychiatrists to develop insights into the illness and prevent relapse. She also refers to the importance of treatment adherence, and in particular medication adherence in sustaining recovery. She also suggested that she empowered herself by being independent, responsible, and patient, enduring ongoing treatment to facilitate recovery. These elements are also part of the user-based approach to recovery (Schrack & Slade, 2007). Moreover, Karima's assertion that long-term maintenance and acceptance of treatment is a critical element in preventing relapse is confirmed by the literature (Baylé, Tessier, Bouju, & Misdrahi, 2015; Llorca et al., 2013; Robinson et al., 2002), with long-term continuous treatment adherence being considered imperative to achieve and sustain recovery. Karima's decade without relapses further supports this view.

Relapse awareness, another aspect of insight into psychosis after discharge, was also mentioned in the field notes for Eliana's interview. She was aware of the signs of her last relapse when she started to see snakes and other things which scared her. She asked her sons to admit her to the hospital because she knew she was experiencing the start of a relapse.

From Eliana's viewpoint, her identification of the early warning signs of relapse, the visual hallucinations that frightened her, which allowed her to plan to be admitted, reflected her insight into psychosis and led her to seek early treatment. A period of one to four weeks of early warning signs often precedes a relapse (Birchwood, Spencer, & McGovern, 2000).

Eliana's recognition of warning signs allowed her to react when she had a psychotic relapse and facilitated her admission, highlighting the importance of a certain level of understanding of and insight into psychosis.

The interviewees reports of how their thoughts, perceptions, responses, relationships and use of technology affected their recovery by preventing or recognising relapse were explored using the existentials of van Manen (2014). Health professionals play an essential role in

assisting women such as Zahra, Jana, and Karima to sustain recovery by spending time and talking with them about their stories and how they can attain user-based recovery (Nxumalo Ngubane et al., 2019). Giving professional time to women can help them to develop additional means of achieving recovery, such as acceptance of illness, as in the situations of Abeer and Karima, and motivating them to proceed with user-based recovery (Schrank & Slade, 2007).

In addition to their stories about how they recovered from symptoms and managed relapses after discharge, the interviewees offered perspectives on how they recovered by engaging in other aspects of life such as education, employment, and religion. This focus is illustrated in the next sub-theme.

11.4.4 Subtheme 4: Experiencing a recovery in terms of education, employment, and religion

The interviewees' experiences of life which helped their recovery from psychosis were understood using the lived body lifeworld existential. Part of these activities related to religion, which impacted women's recovery from psychosis through faith and relatedness to God or through relating to others during religious activities; these connections were investigated with the lived self-other. The use of technology as part of religious activities was analysed using the lived cyborg (van Manen, 2014).

Spirituality through religion and finding purpose through work and education are emphasised as components of user-based recovery (Schrank & Slade, 2007). Moreover, the facilitation of recovery by employment was studied by Hitch, Pepin, and Stagnitti (2013). They found that consumers discussed successful recovery from psychosis through the lens of such engagement, referring to maintenance and moving into meaningful working activities to support healthy daily living and occupation (Hitch et al., 2013). However, when seeking to

engage in community activities such as employment after discharge, some consumers face various barriers as a consequence of psychosis; among these, the most significant barrier generally found is stigmatisation (Alyahya et al., 2022), which might hinder their recovery.

Some women in this research reported believing that engaging in important community activities could help them recover after discharge, including completion of their education and employment. Afaf planned to complete her education and find a job to help her recover. She said: ‘Now I am recovered and become normal, I will continue my education for my future career’ (p, 1, lines 29-30). The field notes for Najat suggest that she believed that improving herself by finding a job would help her to recover more quickly.

Afaf stressed her readiness to complete her education, and both she and Najat highlighted their willingness to work: these activities may reflect their views of themselves as being active members of the community, which may, in turn, help them with recovery. Abel et al. (2010) reported that women with psychosis are more likely to be employed than men with psychosis and more likely to retain their social support systems after experiencing illness. This social support for employment among women may help explain the confident tone taken by Afaf and Najat about finding jobs to enhance their recovery.

The final aspect impacting some women’s recovery experience is related to religion, either in terms of their faith in God or their adoption of religious practices and activities to aid recovery. The KSA community is mainly Islamic, and this religion influences most of individuals in the community in terms of their beliefs and activities across all life circumstances, including when they experience illness. Islamic individuals also generally follow Islamic beliefs and practices related to recovery from mental illness (Saged et al., 2020). Saged et al. (2020) found that 98% of Muslim individuals with mental illness believed that having deep faith in Allah and reading or listening to the Quran (the Islamic holy book)

support healing, therefore viewing these as essential aids for recovery from illness, even with adherence to medication. The reasons for this belief in the Quran as a source of recovery include the fact that the Quran is an essential part of their lives, and engaging with it helps consumers to feel peace of mind, free from problems and illness (Saged et al., 2020).

In the present study, the impact of religious beliefs and activities on recovery from psychosis after discharge is revealed by some comments offered by interviewees. Sahar illustrated the belief that religious practices and belief, faith and attachment to God helped her to recover from psychosis: ‘Some of the most [important] factors that helped me to overcome my illness were that I [became] deeply attached to Allah, reading, and listening to the holy Quran and feeling every single word of it’ (p. 1, lines 23-24). Jana described her experience of recovery as being rooted in religious activities after her discharge from hospital, expressing how these activities inspired others with mental illnesses who attended these activities:

I was engaged in the Islamic field and its activities outside the hospital.... I presented valuable lectures, [and] each lecture had a value and meaning which impacted people remarkably, to that extent the members [contacted] me on WhatsApp, thanked me and saying [how I] influenced [them]. One of my lectures that impacted them was ‘life does not accept weak people’ ...there were some women with [mental] illnesses who told me that my words influenced them. I was saying [in that lecture] that a person can live even they have an illness. Life does not accept weak people means that a person should not look to themselves, even if they have a mental illness, as being lost, [or think that] mental illness is the worst.

On the contrary, it is more like any other [physical] illness, like hypertension and diabetes. [A person] must live life and become stronger than before, as ‘life does not accept weak people’. Despite [illness, they can] have family life... humans must get used to [all sorts of things]. (p. 2, lines 64-74)

Both Sahar and Jana reflected on how their religious experiences helped their recovery from psychosis. By developing her faith in God and reading the holy book, Sahar felt she aided her recovery with the healing influence of the Quran; belief and remembrance of God have an influence in the responses of 92.6% of Muslim consumers with psychosis where their Islamic

perspective and belief in their recovery are acknowledged (Saged et al., 2020). From Jana's perspective, her presentation of religious lectures helped her recovery. These lectures offered spiritual motivation based on accepting and recovering from mental illness, inspiring others with mental illness in their recovery. The technological influence of the use of WhatsApp enabled the sharing of the appreciation of others of her activities. Generally, Jana highlighted the impact of sharing a consumer's perspective on how to recover with others as part of her spiritual and religious perspective, enhancing her recovery journey. Religion and engagement in religious activities contribute to recovery of consumers with psychosis (Nxumalo Ngubane et al., 2019), as confirmed by Sahar and Jana's perspectives.

Overall, the perspectives of interviewees on their prospects for education and work after discharge and the impact of religion on recovery are positive. These views of women were investigated using the existentials of van Manen (2014). Religious beliefs and activities and finding purpose through work and education are components of user-based recovery (Schrang & Slade, 2007). In order to support women in recovery by resuming life activities such as employment and education, and to help women like Afaf and Najat seek work after discharge as a means to aid recovery, mental health facilities should cooperate with career services to support the employment of women after discharge (Martin & McKee, 2015). Such services could offer help with career planning, offer important job and work-search skills, support resume writing, teach interviewing techniques, provide pre-and post-employment support, and consumers access appropriate education and training programs (Martin & McKee, 2015). Such collaborations between mental health facilities and career services, if targeted at women such as Afaf and Najat, would facilitate their recovery in the community, based on a sense of empowerment.

11.5 Conclusion

This chapter has explored the experiences of KSA women living with psychosis. It began by examining the theme of experiences with first-time psychosis, followed by the theme of experiences during admission and follow-up in mental health facilities; the chapter ended with a discussion of the theme of experiences after discharge. These three main themes were identified using the lifeworld existentials of van Manen (2014). The women's experiences of living with psychosis and their understandings of and insights into, their perceptions of, feelings about, and responses to psychosis were explored. These experiences were impacted by women's relationships when living with psychosis, including those with family, friends, others in the community, mental health professionals, including nurses, and their relationships with God. The women started their experiences by reliving some events which caused first-episode psychosis in adolescence and young adulthood. Following onset, and as a part of experiencing psychosis, admission to mental health facilities and the spaces in these facilities impacted the healing of the women. Finally, living with psychosis in the presence of TVs, phones, laptops, CCTV, the internet, and WhatsApp affected their psychosis and recovery. Moreover, to understand the meanings of the drawings and notes of some women, van Manen's (2014) vocative analysis method was used in the pre-analytical stage of interpreting the texts phenomenologically.

Regarding the onset of psychosis, the women presented broad perspectives on the causes of psychosis. Many reflected that continuous or exceptional stress triggered the onset of psychosis, which suggests that it may be worthwhile allocating services to the families of those identified as vulnerable to psychosis to educate both the family and community on how to help vulnerable individuals to deal with stress that may trigger its onset. Many of the women in different stages of psychosis showed different levels of insight and understanding

of psychosis, and a sub-theme regarding insight into psychosis was identified in each of the three main themes.

The role of the family in women's experience of psychosis was important for many interviewees, either supporting or distressing them, depending on the family's level of knowledge, especially at the beginning of psychosis and after discharge. Most women suggested that their families lacked knowledge about dealing with them, particularly after discharge, which hindered their recovery. Family knowledge potentially reinforcing recovery, particularly concerning supporting medication adherence, was noted by one woman (Zahra), however, her father was educated about medication by her psychiatrist and was then able to help her regarding the side effects. Family psychoeducation can address problems of medication non-adherence and misunderstanding of psychosis and may also reduce the stigma of psychosis within families.

Many views about hospital services and nurses' care emerged, creating a further sub-theme, and the women made several recommendations to improve service and care. They recommended allocating consumers in the wards according to their acuity level, increasing the number and variety of educational and other activities in the facility, decreasing the use of seclusion and restraints, and empowering women by giving them a choice of treatment and the nurses they prefer to look after them, where possible.

In mental health facilities, *the need for a healing space* was stressed by many women. Managers of these facilities should involve consumers in redesigning these facilities to make them more suitable for mental health care. Interviewees emphasised the necessity of providing green spaces and facilities such as kitchens. If these essential requirements are provided, the women will be able to live in a homely welcoming environment rather than

feeling that they are ‘locked in a box’ as Joud suggested, or in a jail-like space, as Jana described it.

After discharge from hospital, offering psychoeducation to women about psychosis might help their recovery and medication compliance. Educational sessions run by nurses could help address any gaps in knowledge, especially about medication, an issue raised by many interviewees. Finally, returning to work, completing their studies, and taking into consideration their religious faith and activities were represented by many women as assisting in their recovery from psychosis, and these were identified as a specific sub-theme. Regarding work in particular, mental health facilities should be advised to develop proactive collaborations with career services to help women looking for work after discharge gain suitable employment, thereby enhancing their recovery from psychosis.

Overall, the interviewees highlighted many insights into their experiences and need to recover; they insistently stressed elements representing user-based recovery (Schrunk & Slade, 2007). These include the need for mental health professionals to engage with, and educate, the families of consumers, decrease the use of restrictive practices based on physical care only and provide holistic care, empower women by giving them the right to share in decisions affecting them, and help women to find purpose in life through returning to work and completing their education (Schrunk & Slade, 2007). The women also recognised many other factors supporting user-based recovery (Schrunk & Slade, 2007). These include the support of family and community to reduce stigma, spirituality enhancement through faith in God and religious activities, symptom management based on knowledge about the illness and adherence to medication and treatment, acceptance of the illness, their adjustment of treatment strategies to suit their needs and taking responsibility to recover (Schrunk & Slade,

2007). These aspects revealed the need for mental health managers to address women's insights by to build this approach to recovery.

Chapter Twelve: Conclusion

12.1 Introduction

This chapter concludes the exploration of the experiences of several KSA women with psychosis and the nurses who care for them to gain understandings from their perspectives. These experiences were explored using van Manen's (2016) hermeneutic phenomenology, which allowed the researcher to develop an in-depth understanding of the experience of psychosis from multidimensional perspectives. This chapter provides a summary of essential insights gained from the participants' perspectives and makes recommendations based on these insights.

12.2 Drawing the threads together

This study has generated multiple insights regarding the experiences of women with psychosis and those of the nurses providing care to them. The stories of the individual participants have been inspiring and not infrequently, moving. Forty-two participants overall (twenty-one nurses and twenty-one women with psychosis) contributed to this research.

The nurses described how they experienced caring for women with psychosis in KSA. Van Manen's (2014) lifeworld existentials, particularly those of lived space, lived body, lived self-other, lived cyborg, lived things, and lived time, supported the analysis of the nurses' views. Three major themes were identified: experiencing mental health spaces while providing care to women with psychosis; understandings and emotions experienced when providing care to women with psychosis; and nurses' relationships with others while providing care to women with psychosis.

Similarly, based on the women's descriptions of how they experienced the phenomenon of psychosis, van Manen's (2014) six main lifeworld existentials were used to explore and analyse their perspectives. The women's drawings and writing were also explored using van Manen's (2014) vocative analysis method prior to the phenomenological interpretation of the findings. Three major themes of women's experiences were revealed: the onset of psychosis, admission to or follow-up at a mental health facility, and experiencing psychosis in the community after discharge.

Three literature reviews were undertaken for this research, as reported in Chapters Two, Three, and Four. These were conducted to support the focus and purpose of the main aims of this research and examined research on consumers' perspectives on the experience of, and recovery from, psychosis, and mental health nurses' experiences with, and interventions for, consumers with psychosis. In addition, some work reported KSA-based nursing care for consumers with psychosis as a background to the study.

The aims of the following subsections are to combine the main findings of the literature reviews with those gained from the participants, and to highlight new findings identified in this research.

12.2.1 Key insights from nurses' perspectives

The findings from the interviews with the nurse participants, which were discussed in Chapters Nine and Ten, had important parallels with the evidence identified in the literature review in Chapter Four. There was consistency about the importance of supporting medication adherence and family involvement, particularly in terms of nurses and families working with and supporting consumers to prevent relapse, and the relevance of social stigma with respect to care and recovery.

Some new insights from this study regarding the impact of consumers' families and social stigma were based on nurses' comments that they were not permitted to communicate with or educate the women's families about psychotic symptoms or medications. Moreover, social stigma hindered nursing care, and the women's families avoided or withheld help, particularly in cases where they refused to communicate with nurses about consumer care.

Based on the analysis of nurses' perspectives in Chapter Nine, nurses' understandings of psychosis varied significantly, and this affected the quality of care they were able to give.

The literature reviews in Chapters Two and Four supported significant issues with how nurses' understandings of psychosis affected their responses to consumers. There were indications that when nurses have a limited understanding of psychosis, this may engender specific fears and anxieties about the provision of care to consumers with this illness. This study reveals that these fears may arise from the limited education on psychosis offered to them at the beginning of their careers. The issue of nurses' qualifications being low or not specific to their roles, based on their demographic information (Chapter Six), was again consistent with the literature on the KSA context (Chapter One) and the literature review (Chapter Two). The KSA nurses held a mixture of Diplomas and Bachelors' degrees in general nursing, and very few had any form of specialisation in mental health nursing. Nurses participating in this study also often had no advanced specialised mental health nursing training before working with consumers. The limited education of nurses may lead them to use trial-and-error methods of treatment rather than drawing on best practices.

The study revealed that nurse participants had an inadequate understanding of psychosis. Some blamed this on the lack, or limited availability of, in-service education. They also believed that when it does exist, such training is often uninteresting and outdated. The ongoing shortage of nursing staff also limited nurses' attendance at in-service training

programs. On-going shortages of staff also added to the emotional labour experienced by nurses. Based on the findings, this emotional labour is exacerbated by and causes absenteeism and sick leave, creating a vicious cycle. This issue may also be compounded by other staff not recognising the importance of nursing roles and regularly asking nurses to perform other or additional work. Many different feelings and responses represented by the effects of transference and countertransference were acknowledged by nurses as impacting upon the care they provided. The nurses' views also reflected their experiences of stigma about caring for women with psychosis, and some acknowledged their dislike of caring for the women or labelled women with psychosis by their symptoms.

The nurses' experiences in this study are consistent with those in the literature reviewed in Chapter Four in relation to engaging in the development of therapeutic relationships. The relationships of nurses with the women to whom they were providing care were an essential aspect of their experiences and were highlighted as a significant aspect of their practice regarding consumers with psychosis.

The nurses' descriptions in Chapters Nine and Ten were also supported by the literature review in Chapter Two regarding the language difference issues for expatriate nurses who do not speak Arabic very well and the impact this has on their provision of care. The results suggest that these language differences limited their engagement with consumers and their families in the development of treatment plans and the provision of holistic care. The expatriate nurses' perspectives in this study were also consistent with evidence reported in the literature review in Chapter Four. Notably, cultural considerations significantly impacted nurses' understanding of psychosis and their interventional practices. Language and cultural differences can create communication gaps with consumers, which is problematic, as communication is central to the development of effective therapeutic relationships. Nurses in

the current study viewed such gaps as having an adverse impact and limiting their understanding of the women with psychosis in their care.

This study has also afforded new insights into nurses' daily experiences of offering care in KSA hospitals. The nurses in this study highlighted some current dilemmas in mental health facilities, including the fact that the physical environment of mental health facilities does not promote healing. The perspectives of participants reflected their experiences of current facilities as jail-like spaces. This was particularly due to the lack of gardens, ventilation, fresh air, sunlight, and recreational spaces. Safety problems were also identified in both inpatient wards and in OPDs. Limited childcare and food facilities for nurses were also highlighted as issues.

New aspects also emerged regarding nurses' experiences of relationships, and some conflicts between nurses and their colleagues were revealed. The nurses highlighted a lack of collaboration between members of their mental health teams, and the managers' lack of appreciation of their work. Nurses further reported that specific symptoms of psychosis complicated their relationships with the women in their care, particularly where these led women to mistrust nurses, which hindered both communication and care provision.

Finally, in terms of recovery approaches in mental health care, the nurses affirmed that they provided physical and custodial care only, and they sympathised with, and tended to over care for, the women. Their current care practices tend to not empower women to be independent and develop self-help and control, nor to engage or educate women and their families. These descriptions suggest these nurses were providing care purely through the lens of service-based recovery.

12.2.2 Key insights from consumers' perspectives

Several findings from women's perspectives (Chapter Eleven) were consistent with the literature reviews (Chapters Two, Three, and Four), and some new insights emerged from this study. The women in the current study raised the issue of language differences when nurses did not speak Arabic well. Furthermore, several issues arising from the women's perspectives reflected psychosocial problems and the deterioration of relationships based on stigma of consumers with psychosis. These issues are consistent with those in the literature reviews reported in Chapters Two and Three. The stigmatisation of psychosis creates further barriers to recovery for consumers. While the women in the current study did not use the term *stigma*, their views reflect the impact of social stigma. Their experiences of being rejected, divorced, or abused by others, along with the associated social problems and deterioration of relationships, highlight the sorts of social stigma experienced by women which may hinder recovery from psychosis.

Enablers for recovery from psychosis which emerged from some women's views in the current study were also supported by aspects of the literature review of consumers' perspectives (Chapter Three). These reflect the need for consumers to adopt positive attitudes to recovery, have belief and faith in themselves, accept psychosis as a manageable illness, commit to taking medication in the long term, and continue their education and seek work. Religion, spirituality, and faith in God were also viewed as enablers of recovery. However, the impact of religion on consumers' recoveries was based on their membership in a community in which religion influences most aspects of life, including recovery from illness. The views of the women highlighted similar dilemmas to those of the nurses in terms of the insight that the environment of KSA mental health facilities does not help women's healing. There were also limited educational activities available for women in the facilities.

Furthermore, CCTV in the women's rooms, and the replacement of physical observation with electronic devices, were identified as tending to escalate specific psychotic symptoms. The absence of separate high-dependency and low-dependency units was also identified as an issue causing dissatisfaction with the current mixing of women of differing acuity in single wards.

Further new insights into hospital services and nursing care were offered, highlighting the influence of such matters on the women admitted to such spaces and using the services. In this study, the women with psychosis who were interviewed expressed dissatisfaction with restrictive practices. The women highlighted that the nursing care provided hindered their recovery and stressed the need for greater levels of communication from nurses. A lack of shared decision making between women, nurses, and other mental health practitioners on treatment was also felt to be unhelpful.

As the KSA community follows strict norms, the impacts of these on the women's experiences was also revealed through exploration of their personal stories. Many new insights were developed in this work regarding issues within the cultural community and the impacts of consumers' families on the onset of illness. The adverse impacts of family attitudes on the onset of psychosis were also highlighted and identified as being mainly due to a lack of understanding of this illness. Women reflected that they felt continuous or excessive stress triggered onset, with the sources of stress including family matters and educational pressures.

The women also highlighted several new aspects regarding how psychosis is impacted at different stages, roughly related to onset, after admission or follow up, and after discharge. Some women offered narratives reflecting the development of insights into psychosis, while

others had limited awareness of the illness, which might have contributed to women's belief that they did not need to take medication.

In their interviews some women emphasised their recovery experiences after discharge. The women believed in many elements that may be viewed as a user-based approach to recovery. These views highlighted differences between women's and nurses' experiences regarding the recovery approach, and the women were often aware of how to empower themselves to recover, although the mental health care offered to them did not meet their needs.

Overall, the present study provides multiple insights into the experiences of the women and nurses interviewed. Their understanding of psychosis, language differences, the need for healing spaces, and their relationships with family have several implications. However, some limitations to this study need to be presented before moving to the recommendations. These limitations are discussed in the following section.

12.3 Limitations of this study

According to van Manen (2016), phenomenological studies are not generalisable. However, the value of phenomenological studies is related to the insights they generate, and people in other contexts may find these insights useful and applicable. A limitation of this study is that the participants were drawn from a specific area of KSA. Therefore, the study cannot be assumed to provide generalised views relevant to the entire KSA population.

In Hospital A, the interviews with all women with psychosis were reported in the form of field notes, as audio recordings were not permitted. Field notes are not as precise as a transcribed audio recording. Therefore, the interviews with women at Hospital B, where audio recording was permitted, were able to be investigated in more detail than those from Hospital A.

However, while the findings of the study are limited by the methodology and the context, the information gained is important for working with women with psychosis in KSA and for mental health nursing in general. Despite these limitations, this research has contributed to knowledge concerning the experiences of women with psychosis in KSA and the nursing care they receive. The recommendations in the following section recognise the methodological limitations but also draw on the significance of the results.

12.4 Recommendations

Recommendations arising from the findings of this study fall into four main areas: nursing education, clinical practice, policy, and research, and are presented in the following subsections.

12.4.1 Implications for nursing education

The nurses who participated in this study believed they would benefit from more substantial educational preparation before taking up mental health nursing and viewed this preparation as essential for the appropriate care of women with psychosis. The commonality in participants' perspectives makes it likely that the provision of mental health nursing education when students are undergraduates in KSA does indeed need attention and requires strengthening by relevant education and policy groups. Further, the development of a post-graduate specialty in mental health nursing in KSA would help the country achieve greater alignment with the mental health nursing practice standards commonly achieved in western countries.

In addition to the need for more contemporary mental health nursing education, the nurses highlighted that they would find it beneficial if KSA mental health facilities offered specific, up-to-date, and motivating in-service training and education for nurses already working in various mental health areas, and more specifically in psychosis. In-service training should

also highlight how nurses can use their communication skills in response to various symptoms of psychosis, with the goal of further developing nurse-consumer communication and facilitating the provision of better care. Investment in ongoing education and training would also help nurses to recognise and challenge the effects of stigma and reduce any antipathy related to caring for women with psychosis, as they develop the knowledge and skills to provide nursing interventions more effectively.

12.4.2 Implications for clinical practice

Based on the language differences and issues experienced by the participants, nurses recommend that expatriate nurses be encouraged to learn Arabic, whether through self-directed learning or by being offered Arabic language courses. Many women with psychosis, however, recommended the employment of additional Arabic-speaking nurses in mental health facilities. These ideas can all be viewed as ways to reduce issues with misunderstandings due to language issues and to facilitate improved communication between nurses and consumers. It is important that facilities with expatriate nurses also take into consideration the need to help such nurses by providing sufficient translated materials and interpreters. In addition, the provision of culturally sensitive training for expatriate nurses would help to overcome the cultural and language differences between the nurses, women with psychosis, the women's families, and other staff.

Managers' appreciation of the work of nurses is recommended as an essential way to increase the value of their nursing care. Nurse managers also need to address issues arising from the limited collaboration between nurses and other members of mental health teams. In addition, managers need to recognise and resolve issues associated with nurses being asked to work outside their core nursing roles. Managers should advise other hospital staff, especially psychiatrists, of the importance of supporting nurses to abide by their nursing roles and

interventions, which would assist the nurses to offer more focused and better care to women with psychosis. Some conflicts in relationships between nurses, primarily related to priorities in care provision, which emerged in this research, are potentially linked to limited supervision of the nurses in the hospitals involved. The establishment of adequate clinical supervision by nurse managers could assist nurses to achieve better contemporary mental health nursing practice.

Some nurses in this research discussed many negative feelings and responses, possibly representing transference and countertransference in their provision of care. Facilities provision of education to nurses on how to communicate and build relationships with women with psychosis, based on the development of trust and respect, may also help nurses overcome such negative feelings. Mental health facilities could strive to enhance the psychological support offered to nurses by offering enhanced clinical supervision and promoting self-care among nurses to strengthen their ability to cope with work stressors.

Regarding the spaces in mental health facilities, participants in this study affirmed the pressing need for better healing spaces. Designers should be recruited to help prepare units which are more sympathetic to evidence-based positive outcomes. Managers of facilities should also consider involving consumers in redesigning their facilities to make them more suitable for consumers by enabling them to experience a positive environment during their care. Features such as gardens, good ventilation, exposure to sunlight, access to fresh air, and the availability of recreational facilities were all identified by multiple participants as necessary for healing. Consumers need to be able to experience inpatient areas as welcoming and offering a homely environment for healing. The provision of kitchens which enable consumers to keep and prepare food and drink is necessary.

Similarly, the limited childcare and food facilities for nurses need to be addressed to allow them to look after themselves while at work. Indirectly, this will work to support the provision of better care to women with psychosis. Additional safety measures should also be implemented in mental health facilities, with particular attention being given to the removal of slip hazards in toilet areas, and the present narrow and confining OPD spaces should be expanded.

While some nurses in this study were comfortable with the facilities and approaches available for applying restrictive practices, the women participants tended to view such approaches as punitive and as creating fear. Facility managers and clinical leaders should consider the current global movement towards reducing such practices and find ways to give nurses opportunities to use alternatives to such practices. To further reduce their use, the relevant nursing education departments should also educate and train nurses to identify non-coercive alternatives when caring for consumers.

Many nurses in the study considered that consumers with psychosis and their carers require additional information and education about psychosis and adherence to medication to prevent relapse. Consideration of the most relevant and effective forms of consumer education for the KSA context is needed. Nurses should be engaged in and supported to deliver this education. Nurses who participated in this study also believed in the importance of having further on-going care and education available for the women they discharge from mental health facilities. Planning for this type of education is needed. Psychoeducation in the inpatient area and in the post-discharge context will help health professionals to achieve more realistic expectations of recovery by the women and their families. As the study has shown, issues and conflicts may occur between nurses and consumers' families about both consumers' prospects for recovery and the care provided. Nurses in this study identified that these occur

primarily due to the women's and families' misunderstandings of psychosis. Such psychoeducation should be offered alongside training nurses to ensure that they too are well informed about psychosis and about the various approaches which promote recovery. It would be particularly worthwhile to allocate psychoeducational services to the families of individuals identified as vulnerable to psychosis, to educate such families and the wider community to help vulnerable individuals deal with stressors that may trigger onset of psychosis, as these factors were noted by many women as an element in the illness.

Many nurses also offered recommendations about involving consumers and their families in decision making through increased levels of communication and psychoeducation. This suggests that nurses are supportive of the development of shared decision making with consumers, particularly when seeking to achieve post-discharge and longer-term treatment plans. The women participants similarly identified the need for planned and shared decision making between consumers, nurses, and other members of the mental health team in relation to treatment plans.

In terms of combating stigma, the nurses also believed that families withheld care and avoided supporting nurses in their care for women with psychosis. This may be linked to social stigma of psychosis, which in turn suggests the need for the development of specially designed community mental health education programs to combat, counteract, and break down social stigmas associated with mental health disorders, especially psychosis.

Regarding recovery from psychosis, some women highlighted the need to complete their education and to find work after their discharge from hospital, which they viewed as important to their recovery. Mental health facility managers should consider implementing a range of resources to encourage consumers' independence after discharge. Such help should include the development of collaborative relationships with organisations which can teach

women how to access the services required to complement the lives they wish to lead after discharge, including support with living independently, studying, and finding work.

The results reveal that the nurses' experiences were mainly related to service-based recovery approaches in their care provision. In contrast, the women's views about recovery emphasised the importance of elements more usually associated with user-based recovery approaches. Setting a user-based recovery approach as the organisational philosophy, supported by strong leadership, is crucial to the development of mental health nursing care.

As this study indicates, understanding consumers' voices would help with the development of an approach to care with multiple user-based recovery components.

12.4.3 Policy implications

This study has revealed the importance of employing sufficient nurses in mental health facilities to meet the needs of inpatients and outpatients. Some nurses suggested that addressing this issue would considerably reduce the stress nurses experience as they provide care to women with psychosis. In addition, higher levels of staffing will address the current challenge of the limited time available for nurses to attend in-service training.

In view of the work stresses and ill-health reported by the nurses, as discussed in Chapters Eight and Nine, policy leaders should consider mechanisms to achieve better support of nurses working in mental health contexts and to reduce their stress levels. Mental health facility managers should monitor staff sickness and absences reported by nurses (particularly those related to stress and working conditions), as a way of developing solutions to these issues. This process will require managers to review and report on nurses' working conditions and address the factors limiting nurses' job satisfaction. The latter currently include limited food facilities and high workloads related to being assigned non-nursing roles. These issues require consideration and corrective interventions by managers.

12.4.4 Research implications

This research is the first women-focused study about the psychotic experience in KSA. Based on the findings of this study, further research on women with psychosis in KSA is required to deepen the insights gained into women's mental health in KSA. Further, while this research explored many cultural perspectives with the views of women with psychosis and their nurses, further investigation of these cultural perspectives is required, specifically on how such factors influence psychosis.

It is hoped that this research will act as a starting point for further phenomenological research exploring what it is like to be a nurse in KSA, to investigate new or more profound aspects of the experience of nursing. Addressing this gap with further studies is essential for the development of mental health nursing research in the country.

12.5 Concluding remarks

As a researcher, I remain grateful for the time and effort which all participants contributed to this study. Their willingness to share their experiences and stories has generated significant insights into the phenomena under investigation. Despite the limitations of this study, the research has been able to contribute to current knowledge concerning the experiences of women with psychosis in KSA and the care they receive from nurses. There are many challenges for women with psychosis at various stages of the illness, as well as for the nurses who care for them. This work may be seen as an important start to the process of shedding light on the development of mental health nursing for women with psychosis in KSA. As they are drawn from participants' insights and the researcher's interpretations of participants' voices, the findings will assist nursing staff and policy makers working in the mental health context to better strategise the development of care for women with psychosis. Women's

experiences of psychosis should be considered in nursing education and practice. In addition, it is hoped that the recommendations on educational, practice, policy and research development emerging from this work will be supported.

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Appendices

Appendix 1: Consent form (nurses)

Project:

An investigation into the Lived experience of women with psychosis and the daily experience of nurses in providing care in Kingdom of Saudi Arabia (KSA).

The aim of the study is to investigate the experiences of KSA women with psychosis, and their perceived needs from nurses to assist their recovery. We will also investigate nurses' understanding of and attitudes towards working with women with psychosis.

You will answer some demographics questions and be interviewed for 30 minutes to 1 hour, which will be audio taped.

Chief investigator:

Dr Ian Munro

Co-investigator:

Prof. Wendy Cross

Student:

Mrs Norah Alyahya

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement, and had it explained to me and I hereby consent to participate in this project.

I consent to the following:	Yes	No
Audio-recording during the interview.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will be used and analysed in research project specified above.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will be published with anonymity and confidentiality.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will only be used for this research.	<input type="checkbox"/>	<input type="checkbox"/>

Name of Participant

Participant Signature

Date

Appendix 2: Consent form (women with psychosis)

Project:

An investigation into the Lived experience of women with psychosis and the daily experience of nurses in providing care in Kingdom of Saudi Arabia (KSA).

The aim of the study is to investigate the experiences of KSA women with psychosis, and their perceived needs from nurses to assist their recovery. We will also investigate nurses' understanding of and attitudes towards working with women with psychosis.

You will answer some demographics questions and be interviewed for 30 minutes to 1 hour, which might be audio-taped or transcribed according to the hospital policy.

Chief investigator:

Dr Ian Munro

Co-investigator:

Prof. Wendy Cross

Student:

Mrs Norah Alyahya

I have been asked as a consumer or as a guardian of a consumer to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement, and had it explained to me and I hereby consent or as a guardian, consent for the consumer, to participate in this project.

I consent to the following:	Yes	No
Audio-recording during the interview if applicable.	<input type="checkbox"/>	<input type="checkbox"/>
If not applicable, transcribe the interview.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will be used and analysed in the research project specified above.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will be published with anonymity and confidentiality.	<input type="checkbox"/>	<input type="checkbox"/>
The data that is provided will only be used for this research.	<input type="checkbox"/>	<input type="checkbox"/>

Name of Participant

Participant Signature

Date

Appendix 3: Guiding questions for interviews

Women with psychosis

- Thinking about the time when you had your first psychotic experience, could you please tell me about the events leading up to that episode of psychosis in as much detail as possible.
- Thinking back to when you first experienced psychotic symptoms, what was that like for you?
- What happened to you over time as you began to recover from the psychotic episode?
- You mentioned that you were admitted to the hospital. Could you please walk me through your experiences of the service there, particularly your experiences with the nurses?
- How would you have preferred the nursing care to assist in your recovery?
- Would you like to share your experiences through writing or drawing? If so, please take your time and think about how you would like to present your experience.

Nurses

- You have probably had some interesting experiences while caring for consumers with psychosis. Can you recall and share some of them?
- Could you describe specific examples of the symptoms you have seen in women with psychosis in your clinical practice?
- Please tell me about your experiences including your responses to women with symptoms of psychosis.
- Could you please describe the enablers and barriers you experience in caring for women with psychosis in detail?
- Tell me about your recommendations for service improvements.

Appendix 4: Participants in the research

Table1: Demographic data of nurses

Item	Number
Total number of nurses:	21
Nurses from Hospital A	11
Nurses from Hospital B	10
Average age	36.9 years
Level of nursing education:	
Diploma	13
Bachelor	8
The specialty of awarded degree:	
General nursing	20
Mental health nursing	1
Average years of experience in mental health nursing	9.7 years
Mental health training:	
Yes	19
No	2
The focus of training (for the 19 nurses):	
Principles of mental health care	18
Symptomatology and mental disorders	17
Psycho-social interventions	12
Psychotropic medications	18

Table2: Demographic data for women with psychosis (taken from the women themselves)

Item	Number
Total number of women with psychosis:	21
Women with Psychosis in Hospital A	7
Women with Psychosis in Hospital B	14
Average age	38.1 years
Marital status:	
Single	8
Married	7
Divorced	4
Widowed	1
Don't know	1
Have children	12
Level of education:	
None	2
Primary	3
Intermediate	3
Secondary	8
University	5
Employment:	
Not employed	19
Employed	2
Diagnosis:	
Schizophrenia	5
Schizoaffective disorder	3
Mood disorder accompanied by psychotic features	7
Postpartum psychosis	1
Don't know	5
Average age when they were first diagnosed	20.5 years
Number of episodes:	
One	2
Two	2
Three	1
Four	3
Five or more	12
Don't know	1
Medications for mental symptoms:	
Anti-psychotics	16
Anti-depressants	1
Mood stabilizers	6
Anti-anxiety and sleeping	1
Other medications for mental health	5
Don't know	4

Appendix 5: Monash University ethical approval



Monash University Human Research Ethics Committee

Approval Certificate

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: 1246
Project Title: An investigation into the lived experience of women with psychosis and the daily experience of mental health nurses in providing care in Saudi Arabia
Chief Investigator: Dr Ian Munro
Expiry Date: 27/01/2022

Terms of approval - failure to comply with the terms below is in breach of your approval and the *Australian Code for the Responsible Conduct of Research*.

1. The Chief Investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved projects including changes to personnel must not commence without written approval from MUHREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of five years.

Thank you for your assistance.

Professor Nip Thomson


Chair, MUHREC

CC: Professor Wendy Cross, Mrs Norah Alyahya


List of approved documents:

Document Type	File Name	Date	Version
Questionnaires / Surveys	Norah nurses survey final (2)	02/11/2016	1
Supporting Documentation	Norah flyer patient final (1) (1) (1)	18/11/2016	4
Questionnaires / Surveys	Norah Patient survey final (2) (2) (3) (1)	18/11/2016	4
Supporting Documentation	Norah flyer nurses final (1) (2) (2)	04/01/2017	1.0
Explanatory Statement	Explanatory Statement template - nurses final	19/01/2017	1.2
Explanatory Statement	NorahExplanatory Statement template - patient final (1)	19/01/2017	1.2
Supporting Documentation	Modifications from Panel Comments 2	19/01/2017	1.1
Consent Form	ASSENT FORM (1)	19/01/2017	1.1
Consent Form	Consent Form - patient final	19/01/2017	1.2
Consent Form	Consent Form nurses final	19/01/2017	1.2

Appendix 6: Hospital A ethical approval

Kingdom of Saudi Arabia Ministry of Health		المملكة العربية السعودية وزارة الصحة
(104)		(111)

IRB Registration Number with KACST, KSA:	H-01-R-012
IRB Registration Number with OHRP/NIH, USA:	IRB00010471
Approval Number Federal Wide Assurance NIH, USA:	FWA00018774



May 2, 2017
IRB Log Number: 17-127E
Department: External
Category of Approval: EXEMPT

Dear Norah Al-Yahya,

I am pleased to inform you that your submission dated April 4, 2017 for the study titled '**An investigation into the lived experience of women with psychosis and the daily experience of mental health nurses in providing care in Saudi Arabia**' was reviewed and was approved. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in an external institution to commence data collection.


We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

Please be advised that regulations require that you submit a progress report on your research every 6 months. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

As a researcher you are required to have current and valid certification on protection human research subjects that can be obtained by taking a short online course at the US NIH site or the Saudi NCBE site followed by a multiple choice test. Please submit your current and valid certificate for our records. Failure to submit this certificate shall a reason for suspension of your research project.

If you have any further questions feel free to contact me.

Sincerely yours,


Review Board (IRB)
Riyadh, KSA
3

E-mail:

Appendix 7: Hospital B ethical approval



المكرمة/ نورة اليحيى سلمها الله

السلام عليكم ورحمة الله وبركاته

رداً على كتابك رقم (بدون) وتاريخ (بدون) والمتضمن طلب الموافقة على إجراء دراسة علمية ضمن مرحلة
دراسة الدكتوراة والتي بعنوان:

**An investigation into the Lived experience of women with psychosis and the daily experience
of mental health nurses in providing care in Saudi Arabia**

فتفيدك أنه لا مانع لدينا من إجراء البحث في هذا الموضوع بشرط الحصول على موافقة لجنة أخلاقيات
البحوث الطبية في التنسيق مع إدارة القسم قبل البدء بجمع البيانات ومقابلة عينة
البحث.

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الرقم:

التاريخ: ١٤٣٨ / ٧ / ٧ هـ

المرفقات: